CVS-Aetna Acquisition Undertakings

CVS Health Corporation (CVS Health) has agreed to acquire all outstanding shares of Aetna Inc. (the "Acquisition"). Aetna Inc. (Aetna) is the indirect parent company of four California health plans licensed by the Department of Managed Health Care (Department). The four health plans are: Aetna Health of California Inc. (Aetna Health); Aetna Better Health of California Inc. (Aetna Better Health); Aetna Dental of California Inc. (Aetna Dental); and, Health and Human Resource Center, Inc. (HHRC), (together the "California subsidiaries").

Aetna Health has filed with the Department a Notice of Material Modification (filing number 20180160) regarding the acquisition by CVS Health.

To demonstrate continued compliance with the Knox-Keene Health Care Service Plan Act of 1975 (Act), codified at Health and Safety Code section 1340 et seq., and the Act's corresponding regulations at Title, 28, California Code of Regulations (Rules), the following entities (collectively, the "Parties") agree to the Undertakings set forth herein and acknowledge that any Orders issued by the Department approving Material Modification number 20180160 are conditioned upon these Undertakings:

- CVS Health
- Aetna
- Aetna Health
- Aetna Better Health
- Aetna Dental
- HHRC

The Parties agree to fully and completely comply with these Undertakings and agree they will not violate these Undertakings.

Financial and Filing Requirements

1. CVS to fund costs of executive compensation due to the Acquisition

Aetna and CVS Health promise the following:

(a) All of the executive compensation by reason of the Acquisition, including change in control payments, acceleration of outstanding equity incentives, CVS equity incentive grants, and CVS signing/retention bonuses (together, CIC Benefit) shall not be paid by the California subsidiaries regardless of which entity has the legal obligation.

(b) CVS Health and Aetna shall have on hand cash and committed borrowing facilities at the time of the closing of the Acquisition that are adequate to timely discharge all obligations relating to the CIC Benefit.

(c) CVS Health shall assume Aetna's debt in the amount of $8,157,000,000 as of September 30, 2018 and it shall remain at the Aetna level and shall not be the responsibility of the California subsidiaries.

(d) No amounts relating, directly or indirectly, to the CIC Benefit shall be the obligation of the California subsidiaries.

(e) No amounts relating, directly or indirectly, to the CIC Benefit shall be charged to or made the responsibility of the California subsidiaries, directly or indirectly, under any reimbursement or cost allocation arrangement.

(f) CVS further represents and warrants that there are no CIC Benefit payments owed by CVS by reason of the Acquisition to any of CVS's officers, directors, or key management.

2. Restrictions on upstreaming of funds

Aetna Health, Aetna Better Health, Aetna Dental, and HHRC shall not declare or pay dividends, make other distributions of cash or property or in any other way upstream any funds or property to their shareholders or any of Aetna Health's, Aetna Dental's, Aetna Better Health's or HHRC's affiliates (collectively, "Affiliate Company Distributions") without adequate consideration if such actions would:

(a) Cause Aetna Health, Aetna Better Health, Aetna Dental and HHRC to fail to maintain at all times the greater of the following:

i. For Aetna Health, 300% of the minimum tangible net equity (which annualized amount shall be calculated by multiplying the applicable current quarter revenues and expenditures by four) currently required by Health and Safety Code section 1374.64(b)(1).

ii. For Aetna Better Health, 300% of the minimum tangible net equity (which annualized amount shall be calculated by multiplying the applicable current quarter revenues and expenditures by four) currently required by Rule 1300.76.

iii. For Aetna Dental, 500% of the minimum tangible net equity (which annualized amount shall be calculated by multiplying the applicable current quarter revenues and expenditures by four) currently required by Rule 1300.76.

iv. For HHRC, 2500% of the minimum tangible net equity (which annualized amount shall be calculated by multiplying the applicable current quarter revenues and expenditures by four) currently required by Rule 1300.76.

v. 100% of minimum tangible net equity as may be required following any future amendment to Health and Safety Code section 1374.64 or Rule 1300.76, or any successor statute or regulation.

(b) Result in insufficient working capital or insufficient cash flows necessary to provide for the retirement of existing or proposed indebtedness of Aetna Health, Aetna Better Health, Aetna Dental or HHRC, as required by Rule 1300.75.1(a).

(c) Adversely affect the ability of Aetna Health, Aetna Better Health, Aetna Dental or HHRC to provide health care services.

For purposes of these Undertakings, "Affiliate Company Distributions" shall not be deemed to refer to payments made under the terms of any administrative service agreement or tax sharing agreement that was filed with and received prior approval from the Department.

3. Material Modification required before guaranteeing, cosigning or assuming loans, or before borrowing

Aetna Health, Aetna Better Health, Aetna Dental and HHRC shall not take any of the following actions prior to the submission of a Notice of Material Modification in accordance with the standards set forth in Health and Safety Code section 1352 and Rule 1300.52.4 and the receipt of the Department's Order of Approval:

(a) Cosign or guarantee any portion of any current or future loans and/or credit facilities entered into by Aetna Health, Aetna Better Health, Aetna Dental or HHRC shareholders, the Aetna Health, Aetna Better Health, Aetna Dental or HHRC affiliates, or any other affiliated shareholders.

(b) Permit any portion of loans obtained by Aetna Health, Aetna Better Health, Aetna Dental or HHRC shareholders or affiliates to be assumed by Aetna Health, Aetna Better Health, Aetna Dental or HHRC unless Aetna Health, Aetna Better Health, Aetna Dental or HHRC are currently a party to a loan.

(c) Allow a pledge or hypothecation of Aetna Health, Aetna Better Health, Aetna Dental or HHRC assets in any way connected with any current or future loans of Aetna Health, Aetna Better Health, Aetna Dental or HHRC shareholders or affiliates.

(d) Borrow any funds or otherwise incur any indebtedness for the purpose of making any Affiliate Company Distribution, except (i) any Affiliate Company Distribution that is made in compliance with this Undertaking, or (ii) a payment made pursuant to any written administrative services agreement or tax sharing agreement between or among Aetna Health, Aetna Better Health, Aetna Dental or HHRC on the one hand, and Aetna Health, Aetna Better Health, Aetna Dental or HHRC affiliates or shareholders on the other hand.

4. Notice of undertakings to creditors

Aetna Health, Aetna Better Health, Aetna Dental and HHRC shall provide written disclosure, by commercially reasonable means, of Undertakings 2 and 3 to any and all future holders of any loans and/or credit facilities of Aetna Health, Aetna Better Health, Aetna Dental or HHRC affiliates to ensure the holder of such instrument(s) has written notice that the satisfaction of any obligations under such instrument(s) is subordinated to obligations of Aetna Health, Aetna Better Health, Aetna Dental or HHRC under the Act and Rules thereunder.

5. Required financial reporting and actuarial opinion

For three (3) years following the issuance of the Department's Order approving the Material Modification (Order of Approval) regarding the Acquisition, Aetna Health, Aetna Better Health, Aetna Dental and HHRC shall file with the Department a Schedule that reports the estimated claims payable; reported or unreported medical liability at the end of each such quarter; and, the amount of the claims payable reported on lines 3 through 6 of Report #I - Part B: Liabilities and Net Worth. This Schedule shall be filed with the Aetna Health, Aetna Better Health, Aetna Dental and HHRC Quarterly Financial Reports filed with the Department each calendar quarter. If filed through eFiling, the Schedule shall be filed as an Exhibit HH-32 and shall be accompanied by a Request for Confidentiality as described below.

The estimated unreported medical liability (incurred-but-not-reported claim liability) at the end of each such quarter shall be prepared by Aetna Health, Aetna Better Health, Aetna Dental and HHRC and by the Aetna Health, Aetna Better Health, Aetna Dental and HHRC or CVS chief actuary, chief financial officer, or other appropriate financial officer, ensuring the unreported medical liability is in accordance with actuarial standards of practice which generally require that the unreported medical liability estimates be adequate to cover obligations under moderately adverse conditions.

Annually, Aetna Health, Aetna Better Health, Aetna Dental and HHRC shall obtain, provide, and include as part of their required financial filings, an actuarial opinion by an independent actuarial or accounting firm reasonably acceptable to the Department.

Upon receipt of a Request for Confidentiality, the Department shall grant confidential treatment to the Schedule filed pursuant to this Undertaking for an indefinite period of time. In each Request for Confidentiality, Aetna Health, Aetna Better Health, Aetna Dental and HHRC shall reference the File Number of this Undertaking and Order, and describe the confidential and proprietary nature of the information provided in the Schedule. The Department shall provide Aetna Health, Aetna Better Health, Aetna Dental and HHRC with appropriate notice of any judicial or other effort to compel the Department to disclose this information in accordance with Rule 1007.

6. Ratio of administrative costs to premium revenues

Aetna Health and Aetna Better Health represent they anticipate that, for the duration of these undertakings, their ratio of administrative costs to premium revenues, as reported in Report #2, lines 1, 2, 3, 4, 5, 6, 7 and 32, respectively, of the Quarterly Financial Reports filed with the Department by Aetna Health and Aetna Better Health, (Administrative Cost Ratio) **shall not exceed 15%, measured on an annual basis**.

In the event Aetna Health's or Aetna Better Health's Administrative Cost Ratio exceeds 15% in any quarter, the plan(s) with the excess Administrative Cost Ratio shall, within 45 days of the end of the applicable calendar quarter, report in writing to the Department the following:

(a) The amount of the excess;

(b) The reasons for the increase in the Administrative Cost Ratio (for example, changes in law, taxes, commission structure, or the overall mix of Aetna Health's and Aetna Better Health's business);

(c) Whether the increase is in any way, directly or indirectly, related to the implementation of the Acquisition;

(d) An explanation of why, in the plan's opinion, its administrative costs are not excessive within the meaning of section 1378 of the Act and Rule 1300.78; and

(e) Whether the increase was caused by a one-time event, and whether Aetna Health's and Aetna Better Health's annual Administrative Cost Ratio is expected to remain at or below 15% despite this event, or whether the increase is expected to impact future quarters such that the annual Administrative Cost Ratio calculation is expected to exceed 15%, in which case Aetna Health and Aetna Better Health shall provide notice of the expected impact on the annual calculation.

For purposes of calculating Aetna Health's and Aetna Better Health's Administrative Cost Ratio pursuant to this Undertaking, administrative costs and premium revenues related to new commercial plan products implemented after the closing of the Acquisition shall be excluded.

7. Tax sharing agreements to be filed as material modifications

After the closing date of the Acquisition, if Aetna Health, Aetna Better Health, Aetna Dental, or HHRC desires to amend, change, terminate or replace its tax sharing agreements, as previously filed with and approved by the Department, Aetna Health, Aetna Better Health, Aetna Dental or HHRC, as applicable, shall file any changes to those tax sharing agreements as a Notice of Material Modification in accordance with the standards set forth in Health and Safety Code section 1352 and Rule 1300.52.4.

8. Plan to pay costs associated with DMHC's review for compliance with undertakings

Aetna Health, Aetna Better Health, Aetna Dental and HHRC shall promptly pay for the reasonable costs arising from activities of the Department with respect to each such plan, including any necessary out-of-state travel, incurred in the course of verifying and auditing compliance by Aetna Health, Aetna Better Health, Aetna Dental and HHRC with each of the Undertakings set forth herein. Such activity shall be conducted at the Department's discretion, in addition to any of the surveys, audits, examinations, or inquiries required or permissible under the Act.

9. No push-down of goodwill from Aetna or CVS

Aetna and CVS shall not use any form of push-down accounting methods that result in the transfer or allocation of any of Aetna's or CVS's goodwill, including goodwill related to this Acquisition, to Aetna Health, Aetna Better Health, Aetna Dental and HHRC.

10. Keep products and benefit designs

The California subsidiaries shall continue to offer products and benefit designs that substantially match the ones offered pre-Acquisition, consistent with law and regulation.

11. No increase in premiums because of the Acquisition

For five (5) years, Aetna Health, Aetna Dental, HHRC and CVS represent and warrant that premiums payable by Aetna Health, Aetna Dental or HHRC enrollees (including copayments and deductibles) shall not increase as a result of direct costs incurred in financing, analyzing and/or consummating the Acquisition (Acquisition Costs). Such costs include but are not limited to, attorneys' and investment bankers' fees, travel expenses, the CIC Benefit, due diligence expenses, and expenses related to concurrent or future acquisitions by CVS affiliates, other than Aetna Health, Aetna Dental and HHRC.

Aetna Health, Aetna Dental, HHRC and CVS further represent and warrant that, subject to any exceptions filed with and approved by the Department.

(a) Aetna Health's, Aetna Dental's and HHRC's practices and methodologies for determining premium rates in the California market after the Acquisition shall not materially vary from those plans' pre-Acquisition practices and methodologies.

(b) No debt rating factor relating to the indebtedness that CVS has incurred to finance the Acquisition shall be directly included in Aetna Health's, Aetna Dental's and HHRC's premium practices and methodologies post-Acquisition.

(c) In the event there are reductions in the level of reimbursement of Aetna Health, Aetna Dental, or HHRC health care providers, as defined in Health and Safety Code section 1345(i), such reductions shall not be directly attributable to the Acquisition Costs.

(d) If there are reductions in the benefits of Aetna Health, Aetna Dental, or HHRC products sold in California markets, such reductions shall not be directly attributable to the Acquisition Costs.

12. Filings to demonstrate compliance with Undertaking 11

Aetna Health agrees that controlling health care costs is of the utmost importance. For a period of three (3) years following the closing date of the consummation of the Acquisition:

(a) Aetna Health and the Department will meet approximately 30 days prior to the submissions of each HMO small group quarterly rate filing to review the upcoming filing;

(b) Aetna Health will provide the Department with annual income statements specific to small group HMO for calendar years 2015 through 2020. Statements as of 2017 will be submitted with the first small group quarterly rate filing at least 90 days from the consummation of the Acquisition and statements for 2018 through 2020 will be filed by April 15th of the following year. With each quarterly rate filing submitted, Aetna Health will include (1) a two year forecast of medical cost trend and profit margin; and (2) a two year historic summary of medical cost trend and profit margin;

(c) In the event that a forecast varies more than 2% from the amount of the forecast 12 months previously, Aetna Health will provide such additional information as may be requested by the Department to explain the variance. Information provided may include but not be limited to data and models used in Aetna Health's trend development;

(d) Consistent with the Department's historical information requests, Aetna Health shall provide information requested by the Department to support its review of a filing within five business days; and

(e) Annually, through eFiling, as an Exhibit HH-32, within sixty (60) days following the end of the calendar year, Aetna Health, Aetna Dental and HHRC shall file a certification, signed by the Aetna Health, Aetna Dental, HHRC, Aetna or CVS chief actuary, Chief Financial Officer or similar officer, certifying Undertaking 10 has been met for the prior year.

(f) The Department will grant confidential treatment, to the extent permitted by law, to the information filed pursuant to this Undertaking 12 and will provide Aetna Health with appropriate prior notice of any judicial or other effort to compel the Department to disclose this confidential information in accordance with California Code of Regulations, title 28, section 1007.

13. Keep premium rate increases to a minimum

CVS Health and Aetna Health agree that controlling health care costs is of the utmost importance. For any Aetna Health premium rate increase deemed unreasonable or unjustified by the Department, Aetna Health shall meet and confer with the Department and make a good faith attempt to resolve any differences regarding the premium rate increase. This applies to all commercial lines of business subject to rate review by the Department at the time the rate is filed.

14. Key functions and management based in California

For a period of five (5) years, CVS Health and Aetna commit to keeping the Chief Executive Officer/President(s) overseeing the California operations of Aetna Health, Aetna Better Health, Aetna Dental and HHRC based in California, as well as the leaders responsible for local functions described below. CVS and Aetna further commit that health plan job functions performed by employees in California who directly interact with members and providers in California, as of January 17, 2018 (the date Aetna Health filed its material modification with the Department), except as approved by the Department to be performed elsewhere either before or after the Acquisition, shall continue to be performed in California after the Acquisition consistent with their past practices. After the Acquisition is completed, Aetna Health, Aetna Better Health, Aetna Dental and HHRC shall maintain leaders and personnel in California to assure adequate organizational and administrative capacity and to perform, at a minimum, the following functions consistent with the plans' practices in effect prior to the Acquisition:

(a) Clinical decision-making and California medical policy development by a chief medical officer(s) and appropriate clinical personnel responsible for California medical decision-making and California medical policy, including determination of Aetna Health, Aetna Better Health, Aetna Dental or HHRC prescription drug formularies.

(b) Prior authorization and referral functions.

(c) Enrollee grievance and appeal functions.

(d) Network management.

(e) Provider services, including membership accounting and provider directories.

(f) Clinical decision making in connection with the Independent Medical Review process.

(g) Underwriting functions.

(h) Provider Dispute Resolution Mechanism process.

(i) Oversight of claims processing functions.

(j) Key management positions, including the following positions to the extent the positions were held within a plan as of January 1, 2018:

i. One or more Directors

ii. Chief Executive Officer

iii. Chief Financial Officer

iv. Vice President

(k) Key regulator, financial, and compliance officers and other personnel performing state and federal compliance functions, including personnel knowledgeable with the Act and Rules as well as the laws governing Medi-Cal and any other applicable law.

These aforementioned functions shall be conducted in conformity with California standards, and timeframes, as required by the Act. Aetna Health, Aetna Better Health, Aetna Dental, and HHRC confirm to the Department that they intend to maintain offices in California, which shall continue to serve as headquarters for Aetna Health, Aetna Better Health, Aetna Dental, and HHRC health plan operations.

15. Books and records to stay in California unless approved by DMHC

For a period of five (5) years, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC agree they shall not remove, or require, permit, or cause the removal of any Aetna Health, Aetna Better Health, Aetna Dental, or HHRC books and records, as defined in the Act, from California prior to the submission of a Notice of Material Modification in accordance with the standards set forth in Section 1352 of the Act and Rule 1300.52.4 and the receipt of the Department's Order of Approval. Further, notwithstanding any failure or omission on the part of Aetna Health, Aetna Better Health, Aetna Dental, or HHRC, or that of an affiliate, to maintain the records of Aetna Health, Aetna Better Health, Aetna Dental, or HHRC in California, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC agree they shall return to California, as may be required by the Department, within the timeframe specified by the Department, any such Aetna Health, Aetna Better Health, Aetna Dental, or HHRC books and records removed from California without the Department’s express, written permission. This Undertaking shall not restrict Aetna Health, Aetna Better Health, Aetna Dental, and HHRC from maintaining books and records in an electronic format, as long as electronic books and records are contemporaneously available in California.

16. Changes to Administrative Services Agreements must be filed as Material Modifications

For a period of five (5) years, in the event of any Change(s), as defined below, to an administrative services agreement (ASA) to which Aetna Health, Aetna Better Health, Aetna Dental, or HHRC is a party with any Aetna Health, Aetna Better Health, Aetna Dental, or HHRC affiliate, or through which Aetna Health, Aetna Better Health, Aetna Dental, and HHRC receive services, Aetna Health, Aetna Better Health, Aetna Dental,

and HHRC shall file a Notice of Material Modification in accordance with the standards set forth in Health and Safety Code section 1352 and Rule 1300.52.4 and shall not implement the changes prior to the receipt of the Department's Order of Approval.

"Change" is defined for purposes of this Undertaking as an amendment, modification, termination, or replacement of an ASA, which involves any of the following:

(a) The addition of a new service or a change in the scope of services.

(b) A change to reimbursement terms or method of reimbursement for services performed on behalf of Aetna Health, Aetna Better Health, Aetna Dental, or HHRC.

(c) A change to the location of books and records documenting performance of the services performed on behalf of Aetna Health, Aetna Better Health, Aetna Dental, or HHRC pursuant to an ASA, resulting in removal of the ASA provider's books and records outside of California.

(d) A change to the location of performance of any of the functions listed in Undertaking 13 from California to another state or country, or from a state other than California to another state or country.

(e) A change to the legal identity of the entity performing Aetna Health, Aetna Better Health, Aetna Dental, or HHRC functions on behalf of Aetna Health, Aetna Better Health, Aetna Dental, or HHRC pursuant to an ASA, unless the entity is an Aetna Health, Aetna Better Health, Aetna Dental, or HHRC affiliate.

Divestiture and Segregation of Functions

17. CVS Health to continue to contract with other California licensed health plans on an arm's length basis in the normal course of business.

CVS Health agrees that, for a period of at least five (5) years from the issuance of the Order of Approval, the pharmacies and medical clinics (including Minute Clinics) owned, directly or indirectly, by CVS Health shall continue to contract with Department-licensed health plans on an arm's length basis in the normal course of business.

18. Medicare Part D business

CVS Health and Aetna acknowledge and confirm the importance of competition to the market for individual Part D plans in California. CVS Health and Aetna further confirm that CVS Health and Aetna will be divesting Aetna's individual Part D business in California in order to obtain approval for the Acquisition.

(a) CVS Health and Aetna shall continue to make all commercially reasonable efforts in good faith to continue to market, and sell, Aetna's individual Part D business in California, including continuing all planned capital outlays, pricing, marketing and advertising, and service of Aetna's individual Part D business until the sale of the Part D business to Wellcare. Aetna has executed an administrative services

agreement with Wellcare, and at Wellcare's discretion must fully perform the duties and obligations of that agreement until at least December 31, 2019.

(b) CVS Health and Aetna shall continue to operate Aetna's individual Part D business on behalf of Wellcare separately from CVS Health's individual Part D business for the 2019 plan year (January 1, 2019-December 31, 2019) in California, including activities required under the Administrative Services Agreement between Aetna and Wellcare.

(c) During the 2020 plan year (January 1, 2020, through December 31, 2020), Aetna and CVS Health may not directly, or indirectly through an affiliate, offer individual standalone Medicare Part D products under the Aetna Brands of "Aetna," "Aetna Medicare," "Aetna Medicare Rx," "Aetna Medicare Solutions," "Aetna Coventry," "Aetna Medicare Rx Value Plus (PDP)."

(d) Except in connection with marketing of the Divestiture Assets for the 2019 plan year (January 1, 2019 through December 31, 2019), CVS Health and Aetna may not use any Aetna PDP enrollee data relating to the Divestiture Assets for Part D or Medicare Advantage marketing purposes (including direct mail, email campaigns, outbound Medicare Advantage cross-selling activities, and other similar marketing and retention communications), nor may Defendants instruct brokers to do so. Upon Request for Confidentiality, the Department shall grant confidential treatment, to the extent permitted by law, to confidential and proprietary information submitted pursuant to this Undertaking, with appropriate notice of any judicial or other effort to compel the Department to release confidential information, in accordance with Rule 1007.

Correction of Deficiencies

19. Plans to correct all uncorrected survey and financial exam deficiencies

Several of the California licensed health plans owned, directly or indirectly, by Aetna Health have uncorrected deficiencies as identified in recent Department surveys or financial exams. These deficiencies are set forth below.

Within twelve (12) months of the date of the Order of Approval, the California licensed plans shall correct all deficiencies identified below and shall submit a report via eFiling demonstrating how the deficiencies have been corrected.

(a) Aetna Dental —July 24, 2017 Final Report of Routine Survey

i. Deficiency #1: The plan fails to identify potential quality of care issues in exempt grievances and refer these issues for clinical review.

ii. Deficiency #2: The plan's grievance system does not consistently ensure that a written record is made for each grievance received.

iii. Deficiency #3: The plan does not accurately and appropriately maintain a log of exempt grievances.

iv. Deficiency #4: The plan impermissibly processes coverage disputes as exempt grievances.

v. Deficiency #5: The plan improperly processes grievances that are not resolved by the close of the next business day as exempt grievances.

vi. Deficiency #6: The plan's grievance system does not consistently ensure adequate consideration and rectification of exempt grievances.

vii. Deficiency #7: The plan does not consistently acknowledge standard enrollee grievances and appeals in writing within five calendar days of receipt.

viii. Deficiency #8: The plan's Internet website does not maintain an easily accessible online grievance submission procedure.

ix. Deficiency #9: The plan does not consistently include in its denial letters the criteria or guidelines used and the clinical reasons for its decision.

x. Deficiency #10: The plan does not adhere to timeframe requirements when making decisions to approve, modify, or deny healthcare service requests prior to the provision of those services and does not notify providers and enrollees, as required, when it cannot make a decision within the required timeframe.

xi. Deficiency #11: The plan does not demonstrate that statistically valid methods for population analysis were applied in developing the demographic profile for language assistance needs of enrollees.

xii. Deficiency #12: The plan does not validate or define processes and standards to ensure the proficiency of individuals providing translation and interpretation services.

(b) Aetna Health—January 4, 2018 Follow-Up Report from Routine Survey

i. Deficiency #2: The plan failed to:

1. maintain a log of all exempt grievances containing the nature of resolution and the name of the Plan representative who took the call and resolved the grievance;

2. maintain an accurate and complete log of all exempt grievances due to incorrect and/or incomplete categorization of exempt grievances; and,

3. generate reports from the exempt grievance data that facilitate meaningful review by Plan management and committees.

ii. Deficiency #3: The plan improperly processed grievances regarding coverage disputes, disputed health care services involving medical necessity and grievances unresolved by the close of the next business day as exempt grievances resulting in failure to send a written acknowledgement and response to enrollees.

iii. Deficiency #8: The Plan failed to demonstrate that it continuously reviews the operation of the grievance system to identify any emergent patterns of grievances and improve Plan policies and procedures.

iv. Deficiency #9: The Plan does not ensure its delegated providers, rendering utilization management decisions on its behalf, consistently apply criteria or guidelines consistent with clinical principles/processes in its determinations to approve, modify, or deny requests for speech therapy services.

v. Deficiency #14: The Plan operates at variance with documents contained in its application for licensure. In addition, the timeframe regarding prescription drug decisions set forth in the Plan's policies are inconsistent with the timeframes in the Plan's Evidence of Coverage.

(c) HHRC—May 29, 2018 Follow-Up Report from Routine Survey

i. Deficiency #2: The Plan's grievance system fails to include reasonable procedures in accordance with Department regulations to ensure adequate consideration of enrollee grievances.

20. Geographic access to PCPs and hospitals

Aetna Health shall improve its performance in meeting geographic access standards for primary care providers and hospitals and in accurately reporting geographic access data to the Department. Within thirty-six (36) months of the date of the Order of Approval, Aetna Health shall enhance its geographic mapping technology and data analytics capabilities to improve geographic access analysis, monitoring and reporting to the Department. Beginning March 1, 2020, Aetna Health shall submit an annual report to the Department detailing the plan's progress towards satisfying this undertaking.

21. Compliance with Timely Access Standards

For a period of five (5) years, Aetna Health and Aetna Better Health shall comply with the Knox-Keene Act timely access standards, as applicable, codified in Health and Safety Code sections 1367.03, 1367.031 and 1367.035, and the implementing regulations.

Addressing the Opioid Crisis

22. Activities to address the opioid crisis

California has not been spared from the effects of the opioid crisis, which contributes to rising health care costs. In an effort to address the crisis:

(a) Beginning within six (6) months of the date of the Order of Approval:

i. Aetna or CVS Health shall provide **$250,000** annually for three (3) years to the Harm Reduction Coalition (HRC), a non-profit 501(c) (3) organization that works to promote the health and dignity of individuals and communities who are impacted by drug use. Funds shall be used to support one or more of the following activities in California:

- Provide syringe disposal kiosks for Syringe Exchange Programs (SEP) that can place a kiosk for after-hours drop off and/or to place in areas vulnerable to syringe litter in California.

- Provide technical assistance on overdose prevention and response to organizations that must rapidly scale up Naloxone distribution and training programs. Such organizations include, but are not limited to police departments, substance use disorder treatment providers, school nurses and others seeking information on how to use Naloxone and other products in compliance with state and federal laws.

- Provide technical assistance to SEPs, narcotic treatment programs and buprenorphine providers on Medically Assisted Therapy (MAT) and integration with SEP services to support and encourage integration of MAT services with syringe services.

- Expand HRC's two-day workshops to provide technical assistance to local government, health care providers and other stakeholders to introduce harm reduction activities and to plan for adoption or expansion of SEPs, overdose prevention and response programs and other harm reduction activities.

ii. Aetna Better Health will implement the Aetna Opioid Initiative program. The focus of the program is to support members with biopsychosocial needs, assist the members to improve their pharmacy and benefit utilization appropriate to their health care needs, and coordinate care with the members' primary care practitioners (PCP) and other practitioners/providers as needed. The goal is to reduce the supply of opioids and to decrease the rates of overdose. Aetna Better Health will continue to operate the program for a minimum of 3 years.

(b) Within twelve (12) months of the date of the Order of Approval, CVS shall stock Naloxone in all CVS pharmacies in California and train its pharmacists to dispense Naloxone pursuant to a standing order in compliance with all applicable state and federal laws.

(c) Beginning in 2020 and through 2021, Aetna shall submit annual reports to the Department to demonstrate compliance with this undertaking.

Community Investments

23. Charitable contributions

(a) Aetna or CVS Health shall make the following contributions for a period of three (3) years following the date of the Order of Approval:

i. at least **$500,000** annually to California not-for-profits to support programs in California related to addressing the social determinants of health.

ii. at least **$1 million** annually to the California Dental Association Foundation in support of CDA Cares, a program in which volunteer dentists, dental professionals and community volunteers provide dental services to the public at no charge.

iii. at least **$7.6 million** annually to the Health Professions Education Foundation (HPEF), a non-profit 501(c)(3) foundation housed within the California Office of Statewide Health Planning and Development (OSHPD). The HPEF improves access to health care in underserved areas of California by providing scholarships, loan repayments and programs to health professional students and graduates who are dedicated to providing direct patient care in those areas. At least $2 million per year shall be designated for scholarships and $5.6 million per year shall be designated for loan repayment programs with a focus on primary care and mental health providers.

iv. at least **$1 million** annually to establish a grant program to support non-profit organizations in California that provide direct consumer assistance to seniors and persons with disabilities and Medi-Cal/Medicare dual eligible individuals enrolled in managed care health plans, including Medicare Advantage and Part D plans and Cal MediConnect plans.

v. at least **$1,850,000** annually to the Pacific Business Group on Health, a nonprofit 501(c)(3) foundation, to support the expansion of the California Quality Collaborative's (CQC) Practice Transformation Initiative to support small physician practices, focusing on practices with poor performance on asthma and diabetes care, and to improve quality of care and patient experience in underserved areas of California including, but not limited to, the Central Valley, Inland Empire and Imperial Counties.

vi. at least **$150,000** annually to the Santa Rosa Junior College Foundation (also known as the EMS Training Foundation), a non-profit 501(c)(3) foundation, for the purpose of developing and delivering the EMS/Opioid Prevention Training Program to approximately 60 in-person courses and on-line training on the role of EMS, cultural competence, workflow to improve treatment and prevention integration into public health and the use of Naloxone to prevent death from opioid overdose.

vii. at least **$400,000** annually to a foundation or non-profit organization to be determined by the Department to support community-based paramedicine programs. Funds shall be used for oversight and evaluation of a pilot community paramedic project, including an independent evaluator, a core community paramedic education and training program, and support for additional community paramedic sites.

(b) Aetna shall submit an annual report by March 1 of each year confirming that during the preceding calendar year it made the contribution required by this undertaking and detailing to whom the contributions have been made. The reports shall also include how the funds were spent and the outcomes of the projects funded.

24. Expansion of Project Health across California

CVS Health currently sponsors a program called Project Health to provide preventive services at select CVS Pharmacies on a no-cost basis. Beginning within six (6) months of the date of the Order of Approval, and for a period of three (3) years thereafter, CVS Health shall contribute annually a minimum of **$1 million** to expand Project Health to at least 300 CVS Pharmacy locations across California. In addition, CVS Health will add information modules to support/connect seniors and persons with disabilities with local community resource/outreach programs to its California Project Health expansion.

Aetna shall submit a report by March 1 of each year through 2021, demonstrating compliance with this undertaking

25. Supporting Joint Ventures and Accountable Care Organizations

Aetna shall spend at least **$13.5 million** over five (5) years to support joint ventures and accountable care organizations in California using data analytics to inform their analysis and clinical insight in the delivery of highly coordinated, quality care. This investment will include tools for the population health management, care coordination and patient engagement.

Aetna shall submit a report to the Department by March 1 of each year through 2023, demonstrating its compliance with this undertaking.

26. Supporting Provider Pay for Performance

Aetna shall make up to a **$9 million** financial commitment over three (3) years for its participation in the Pay for Performance program managed in California by the Integrated Healthcare Association (IHA) and designed to reward providers who improve clinical quality, resource use, and patient experience through a common set of measures, public report cards, incentive payments and public recognition.

Aetna shall submit a report to the Department by March 1 of each year through 2021, demonstrating its compliance with this undertaking.

27. Investments to support California's health care infrastructure and employment

(a) For a period of three (3) years following the date of the Order of Approval, CVS Health shall spend at least **$150 million** in total supporting the California health care infrastructure and overall economy by building and/or improving CVS facilities in California.

(b) For a period of three (3) years following the date of the Order of Approval, CVS Health shall spend at least **$13.5 million** in total supporting the California health care industry by continuing to provide 1,000 jobs in the economically distressed community of Fresno, California. The investments made under this section shall include investments in leasehold costs, operating costs and cost of employee wages and benefits.

(c) For a period of three (3) years following the date of the Order of Approval, CVS Health shall spend at least **$2.5 million** in total by continuing to provide 125 jobs at the Walnut Creek, California facility. The investments made under this section shall include investments in leasehold costs, operating costs and the cost of employee wages and benefits.

(d) Aetna shall submit a report to the Department by March 1 of each year through 2021, demonstrating compliance with this undertaking.

Improving Quality of Care

28. OPA star ratings

Aetna Health received scores of "poor" or "fair" in a number of the areas in the 2017-18 Office of Patient Advocate Quality Report Card as follows:

(a) Quality of Medical Care:

i. Asthma and Lung Disease Care: Fair (two out of four stars)

ii. Checking for Cancer: Fair (two out of four stars)

iii. Diabetes Care: Poor (one out of four stars)

iv. Heart Care: Fair (two out of four stars)

v. Maternity Care: Poor (one out of four stars)

vi. Treating Adults: Getting the Right Care: Poor (one out of four stars)

vii. Treating Children: Getting the Right Care: Fair (two out of four stars)

(b) Patients Rate Overall Experience:

i. Getting Care Easily: Poor (one out of four stars)

ii. Satisfaction with Plan Services: Fair (two out of four stars)

iii. Satisfaction with Plan Doctors: Poor (one out of four stars)

Aetna Health shall spend at least **$1 million** annually for three years to improve and maintain its scores on each of the above-listed factors to at least a "good" (three out of four stars) by no later than the performance measurement period ending December 31, 2021. Within six (6) months of the issuance of the Order of Approval, Aetna Health shall report to the Department its action plan to reach this goal. Aetna Health shall also submit an annual report to the Department by March 1 of each year through 2022, reporting to the Department on the plan's progress, including action plans and benchmarks, regarding this undertaking.

29. Medi-Cal managed care performance levels

Aetna Better Health shall meet or exceed the minimum performance levels established by the California Department of Health Care Services' External Accountability Set (EAS) for Medi-Cal Managed Care Plans beginning in measurement year 2020 through the term of these undertakings.

Aetna Better Health shall submit an annual report to the Department by March 1, 2021 reporting to the Department on the plan's performance of this undertaking, including action plans and benchmarks if the plan fails to meet any of the minimum performance levels established in the EAS.

30. File cost and quality atlases

For a period of five (5) years, Aetna Health shall file by March 1 the health plan's cost and quality atlas issued by the Integrated HealthCare Association for the most recent reporting year.

31. Diabetes provider-focused program

Within twelve (12) months of the issuance of the Order of Approval, Aetna Health shall implement a three-year provider-focused diabetes program for provider groups that scored a one or two star rating in Diabetes Care on the 2017-18 Office of the Patient Advocate Quality Report Card, with a goal of bringing each rating to, at a minimum, four stars on a five star scale. The program shall include the addition of bilingual diabetic educators, as appropriate, to assist in diabetic education and coaching with the target population and the use of culturally and linguistically appropriate patient education materials that promote and support patient self-management.

Aetna Health shall submit an annual report by March 1 of each year through 2022, reporting to the Department on the plans' progress, including action plans and benchmarks, on this undertaking.

32. Support Optimal Birth Outcomes

(a) Aetna Better Health, through its Promise Pregnancy Program, shall work with Aetna Better Health members, providers and community resources to achieve optimal birth/health outcomes and high quality of care. The Promise Pregnancy Program is a comprehensive maternity care incentive program that includes care management, member reminders and member incentives. The program encourages pregnant members to make early and frequent prenatal visits and post-partum visits. The program includes Care Management, text messaging (text4baby) and incentives to motivate members to keep prenatal and post-natal visits.

(b) Aetna Better Health shall implement the Aetna Neonatal Abstinence Syndrome (NAS) Program. The program shall engage Aetna Better Health pregnant enrollees who have significant opiate use or opiate addictions in prenatal care management and shall continue care management with case manager for the mother and baby for first year of baby's life. The program shall identify and engage Aetna Better Health pregnant enrollees with substance use disorders, provide rapid access to substance abuse treatment, and facilitate ready access to prenatal care with providers who understand the special care needed for these women during pregnancy and delivery.

Participate in Industry-Wide Initiatives

33. Cooperate with the Provider Directory Utility

Aetna agrees that accurate, complete, and accessible provider directories reflecting adequate networks of contracted providers are essential to enrollees. Aetna Health, Aetna Better Health, and Aetna Dental agree that, for a period of five (5) years, it will spend **$3 million** in total to publish and maintain printed and online provider directories in compliance with Health and Safety Code section 1367.27, and will correct any deficiencies in provider directories identified by the Department within applicable regulatory timelines.

Within six (6) months of the date of the Order of Approval, Aetna Health, Aetna Better Health and Aetna Dental shall cooperate with the Provider Directory Utility hosted by the Integrated Healthcare Association. For a period of five (5) years, the Aetna Health, Aetna Better Health, and Aetna Dental shall annually file with the Department a report outlining the status of this. This report shall be submitted by March 1 of each year starting in 2020 and ending 2024.

34. Project to improve encounter data

Encounter data gathered from health care providers is essential for measuring quality of care and setting and adjusting payment rates for capitated providers. In June 2018, Integrated Healthcare Association (IHA) released a white paper, "Challenges in Encounter Data Submissions," which recommends the development of a governance body to oversee and coordinate an approach to standardizing and improving the quality of encounter date, with a focus on education and training, technology improvements, standardization, and incentives. Aetna will continue to provide data.

To support this effort, by no later than six (6) months after the date of the Order of Approval, Aetna shall contribute **$500,000** to IHA to standardize and improve the quality of encounter data and shall spend **$2.5 million** over three years in support of this effort. Within 30 days of making the contribution, Aetna shall cause to be filed with the Department an attestation that it made the required contribution.

General Undertakings

35. Reports to the Department

(a) Aetna shall submit all reports required by these Undertakings through the Department's eFiling portal.

(b) Unless otherwise specified in these Undertakings, Aetna shall submit an annual report to the Department by March 1 informing the Department of Aetna's activities and compliance regarding these Undertakings during the preceding calendar year. These reports shall be organized by Undertaking and shall provide sufficient detail for the Department to determine whether Aetna is compliant with each Undertaking.

36. Enforceability of Undertakings

The Undertakings set forth herein shall be enforceable to the fullest extent of the authority and power of the Director of the Department under the provisions of the Act, including all civil, criminal, and administrative remedies (such as Cease and Desist Orders, freezing enrollment, and assessment of fines and penalties). The Undertakings shall act as an Order of the Director.

CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC acknowledge that the Act's enforcement remedies are not exclusive, and may be sought and employed in any combination deemed advisable by the Department to enforce these Undertakings.

37. Terms and conditions of Undertakings

The Undertakings set forth herein shall be subject to the following terms and conditions:

(a) *Binding Effect.* The Undertakings set forth herein shall be binding on the Plan and its respective successors and permitted assigns. If CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC fail to fulfill their obligations to the Department as provided under the Undertakings set forth herein, CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC stipulate and agree that the Department shall have the authority to enforce the provisions of these Undertakings in a California court of competent jurisdiction or an Office of Administrative Hearing.

(b) *Governing Law.* The Undertakings set forth herein and their validity, enforcement, and interpretation, shall for all purposes be governed by and construed in accordance with the laws of the State of California.

(c) *Venue.* The proper venue of any dispute arising from the Undertakings set forth herein shall be Sacramento, California.

(d) *Invalidity.* In the event that any Undertakings or any portion of any Undertaking set forth herein shall be declared invalid or unenforceable for any reason by a court of competent jurisdiction, the validity or enforceability of any other Undertakings or any portion of any Undertaking shall not affect the validity or enforceability of any other Undertakings, and such other Undertakings shall remain in full force and effect and shall be enforceable to the maximum extent permitted by applicable law.

(e) *Duration.* The Undertakings set forth herein shall become effective upon the date of the Department issues its Order of Approval and except as to those provisions of the Undertakings that contain separate termination provisions, shall remain in full force and effect for three (3) years, ending on the anniversary date of the Order of Approval, unless terminated sooner by CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC with the written consent of the Department.

(f) *Third Party Rights.* Nothing in the Undertakings set forth herein is intended to provide any person other than CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, HHRC, and the Department, and their respective successors and permitted assigns, with any legal or equitable right or remedy with respect to any provision of any Undertaking set forth herein.

(g) *Amendment.* The Undertakings set forth herein may be amended only by written agreement executed by both CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC and the Department.

(h) *Assignment.* No Undertaking set forth herein may be assigned by CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, or HHRC, in whole or in part, without the prior written consent of the Department.

(i) *Specific Performance.* In the event of any breach of these Undertakings, CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC acknowledge that the State of California would be irreparably harmed and could not be made whole by monetary damages. It is accordingly agreed that CVS, Aetna, Aetna Health, Aetna Better Health, Aetna Dental, and HHRC shall waive the defense in any action brought by the Department for specific performance that a remedy at law would be adequate, and the Department should be entitled to seek an injunction or injunctions to prevent breaches of the provisions of these Undertakings and to seek to specifically enforce the terms and provisions stated herein. The Department's right to seek an injunction does not supersede the remedies available to the Director described in subsection (a) of this Undertaking.

Aetna Inc.

Signature: ORIGINAL SIGNED BY

Date: 11/9/2018

Print Name: Edward C. Lee

Print Title: Assistant Corporate Secretary

Aetna Better Health of California Inc.

Signature: ORIGINAL SIGNED BY

Date: 11/9/2018

Print Name: Edward C. Lee

Print Title: Vice President and Assistant Secretary

CVS-Aetna Acquisition Undertakings

Aetna Health of California Inc.

Signature: ORIGINAL SIGNED BY

Date: 11/9/2018

Print Name: Edward C. Lee

Print Title: Vice President and Secretary

Aetna Dental of California Inc.

Signature: ORIGINAL SIGNED BY

Date: 11/9/2018

Print Name: Edward C. Lee

Print Title: Vice President and Secretary

Health and Human Resource Center, Inc.

Signature: ORIGINAL SIGNED BY

Date: 11/9/2018

Print Name: Edward C. Lee

Print Title: Vice President and Secretary

CVS-Aetna Acquisition Undertakings

CVS Health Corporation

Signature: ORIGINAL SIGNED BY

Date: 11/9/2018

Print Name: Thomas S. Moffatt

Print Title: Vice President and Asst. Secretary