SWORN STATEMENT OF JAY KEN IINUMA, MD

1. I am a medical doctor and served as a medical director for Aetna from 2012 to 2015. In that capacity, I performed a medical necessity review for an Aetna member named [redacted] on December 4, 2014. This statement corrects certain misinterpretations of testimony that I gave in the October 16, 2016 deposition in [redacted] lawsuit against Aetna, which do not accurately reflect my practices when I was a medical director at Aetna.

2. When I stated at the deposition that I never looked at a "medical record" while at Aetna, I understood the term "medical record" to refer to the entirety of a patient historical file containing all charts, doctors' notes, laboratory tests, and any other report generated by a treating provider for that patient. In my mind, and based on my experience, this is the definition of a patient's "medical record"—a record of their treatment and medical history. Not only is a patient's medical record generally a very large file or files, in my experience neither patients nor providers submit the entirety of a patient's medical record to Aetna. Patients and providers submit only portions of a patient's medical record for Aetna's review.

3. While I worked at Aetna, to make a determination for insurance coverage, I generally would have reviewed the portion of the patients' medical record that was provided to Aetna by the patient or his providers that was relevant to my evaluation. But this review of the partial submitted medical record was not what I thought [redacted] lawyer was questioning me about. I understood him to be asking me whether I reviewed the entirety of a patient's medical record.

4. In addition to reviewing the relevant portions of submitted medical records, it was also generally my practice to review Aetna nurses' summaries, notes, and the applicable Aetna Clinical Policy Bulletins. After reviewing the relevant, submitted portions of the medical record, the nurse's notes, and the Clinical Policy Bulletin(s), I would apply my medical training, experience, and judgment to reach an appropriate coverage determination.

5. With respect to my evaluation of [redacted] case specifically, my decision was based on the fact that a critical [redacted] test–[redacted]–was not provided to Aetna after multiple requests. Without that [redacted] test, I could not determine that [redacted] care was being provided in a safe and effective manner. And I could not approve insurance coverage without having this assurance that [redacted] was being cared for in an appropriate and safe manner, consistent with generally-accepted medical practices.

6. In circumstances like the one presented by [redacted] case, I rely on Aetna nurses' reports that a needed piece of information is, in fact, missing. Reviewing the submitted portions of the patient's medical record would be pointless because the reason for the coverage decision is that the critical information was not, in fact, given to Aetna. I could not review what was not there. That fact is particularly true in [redacted] case, where the Aetna nurse clearly stated in her notes that she had made multiple efforts to obtain the missing [redacted] test for purposes of the preapproval decision.

7. When I was performing these reviews, if I had questions about a particular case that required the input of a medical specialist, I could reach out with my questions to a group within Aetna comprised of medical specialists in order to get questions answered. If I needed clarification about particular factual items in the file, I could review the submitted portions of the patient's medical record, contact the nurse to ask questions, or have the nurse seek further information.

8. While I do not remember the specific circumstances of my review of [redacted] file in December of 2014, I have looked at Aetna's written record of that review. Based on that written record, I believe that my review of [redacted] case was appropriate and consistent with my general practice when I was a medical director at Aetna. I understand that [redacted] condition is a serious [redacted] condition, and that it cannot be adequately monitored without regular [redacted] tests. I know that serious [redacted] diseases like this one, and the treatments for them, can often have significant side effects. I do not believe it is

consistent with my responsibilities as a physician to approve coverage for treatment for significant conditions like this, without knowing that patient is being appropriately monitored for this treatment.

9. Based on this knowledge, I expected that my letter sent on December 4, 2014, would result in [redacted] providers sending an updated [redacted] test to Aetna so that Aetna would have needed evidence that his treatment was being administered safely, effectively, and consistently with the standard of care.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 13th day of February, 2018 in Los Angeles, California.

Jay Ken Iinuma, MD