

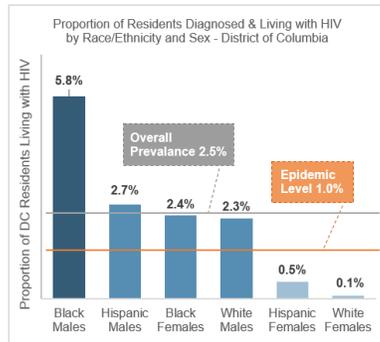


The RED RIBBON Fund

The Red Ribbon Fund (“RRF”) is an investment vehicle that aims to reduce the incidence of HIV/AIDS in the United States through the private funding of a pay for patient performance program (“P4PP”). Influencing patient behavior along the HIV care continuum will lead to higher levels of viral suppression, resulting in significant cost savings to healthcare payers and an opportunity for RRF to deliver both risk-adjusted returns and quantified social impact to impact investors. The initial program will take place in Washington, D.C. and will be expanded to other urban areas in the United States.

THE CHALLENGE

HIV/AIDS Epidemic in Washington D.C.



Despite high investment in HIV/AIDS testing and treatment infrastructure in Washington D.C. (“D.C.”) since the first diagnosis of HIV over thirty years ago, D.C. HIV infection rates remain at epidemic levels comparable to countries in West Africa. Only 47% of HIV positive patients in D.C. exhibit viral suppression, which is half the level typical of developed countries.

Untreated HIV/AIDS Infections Create Ecosystem of Need

Antiretroviral therapy (“ART”) suppresses the HIV virus to non-transmittable levels, preventing related illnesses and disability, new infections, and AIDS-related deaths. Core medical services are easily accessible for the vast majority of HIV positive patients due to high levels of federal funding for treatment programs, and viral suppression takes 6 to 12 months once a patient begins ART. However, retaining patients in care remains the largest challenge to successful treatment and has resulted in low levels of viral suppression in D.C.

Medical Costs: The NPV of direct medical cost savings from avoiding one HIV infection is estimated at \$230,000. Preventing one HIV positive patient from dropping out of care (and thus achieving viral suppression) results in savings of direct and indirect medical expenses with an NPV of \$340,000. Untreated HIV infections lead to opportunistic illnesses, secondary infections, and ultimately, AIDS. The proportion of costs borne by public sector insurance (i.e. Medicaid) or Federal Ryan White funds ranges from 70%-83% and thus increases in viral suppression rates result in significant savings to public payers.

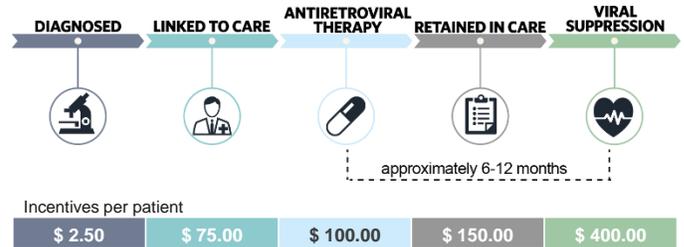
THE SOLUTION

Social Impact Thesis: The RRF will deploy private capital to directly influence patient behavior, thus increasing patient retention in care. Retention in care ultimately results in viral suppression, leading to decreased healthcare costs for public payers. The RRF would target all patients treated under publicly funded programs in D.C., and the RRF model is designed for ready expansion to other urban areas.

Patients would continue to receive testing and treatment utilizing existing healthcare infrastructure, which would continue to be paid by public payers. The RRF would contract with FHI360, a non-governmental organization with experience administering programs at D.C. HIV clinics, to make payment to patients upon achievement of treatment milestones. Milestones are aligned to the HIV continuum and are designed to incentivize patients to remain in treatment.

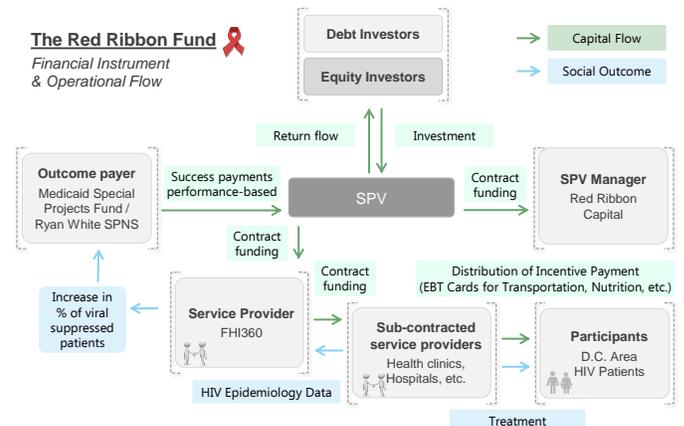
Payments to patients would be in the form of social assistance EBT cards, transportation cards, housing assistance, or gift cards. Benefits increase in magnitude as patients advance along the HIV treatment continuum, aligning patient incentives toward achievement and maintenance of viral suppression. Sub-service providers will receive a mark-up on the value of the payments, therefore aligning service providers’ interests with the RRF along the HIV continuum of care.

Continuum of Care and Patient Incentives



Public health research and pilot projects demonstrate that a P4PP program properly aligned with the HIV care continuum creates lasting behavior changes in HIV positive patients. The RRF would deploy this model on a large scale, which would lead to improvement in patient performance in the most critical phases of HIV treatment and quantifiable savings for public payers.

Investment Thesis: Healthcare payers who benefit from a reduction in costs attributable to HIV/AIDS treatment will commit a pool of funds which will disburse to the RRF upon achievement of increases in viral suppression above a benchmark rate. Shared cost savings represent an opportunity for RRF to realize a market rate return for impact investors while achieving measurable social impact. The model can be easily scaled as investment in infrastructure is minimal, allowing for future rounds of fundraising to target new cities.

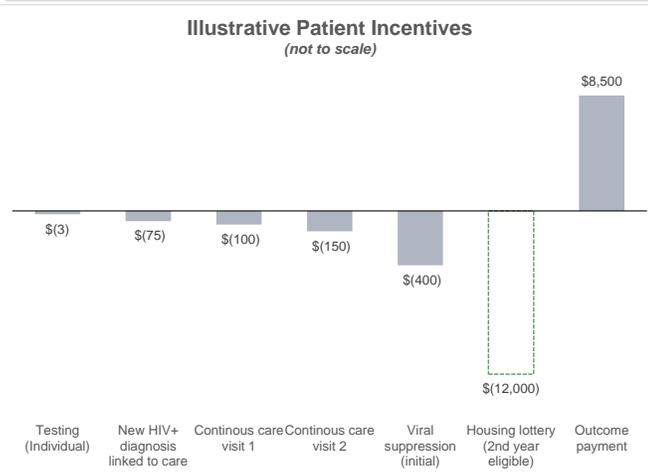
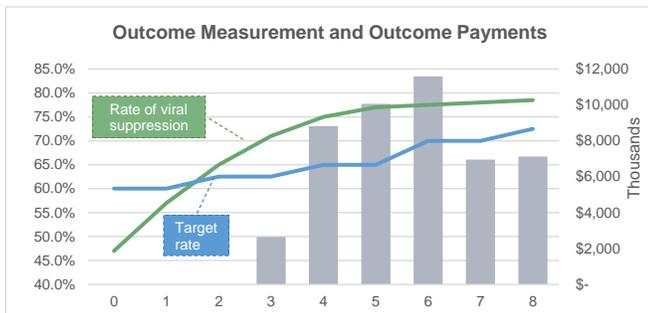
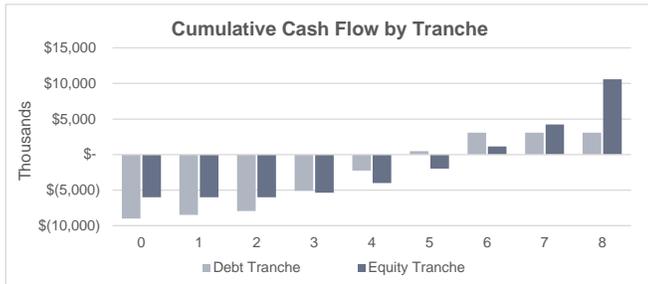
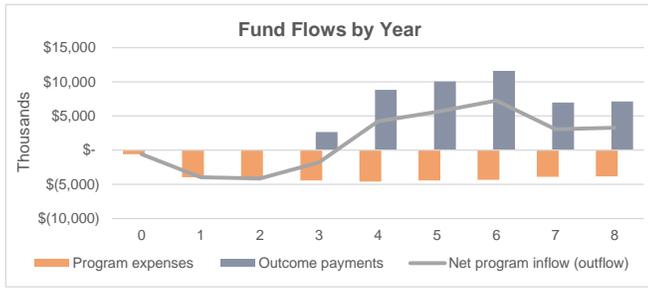


| Investment Profile | |
|---------------------------|---|
| Target Capital Structure | \$15,000,000 / 60% debt, 40% equity |
| Minimum Investment | \$500,000 |
| Target Patient Population | 13,000 HIV+ Patients Served at 20 Selected D.C. Health Care Clinics |
| SPV Life | 8 years |
| Regional Focus | Initial Investment in Washington D.C.; Future fundraising rounds will target greater US |
| Target Investors | Impact investors: institutional investors, trusts, foundations and high net worth individuals |
| Target Gross Return | Debt: 6-8% IRR (6% coupon, 2% revenue sharing) Equity: 13-16% IRR |
| Fees | Management Fee: 2.5%; Success Fee: 5.0% of program revenues |

Outcome Based Payments De-risk Underperformance

- Our structure combines proven elements of Pay for Success (“PFS”) programs with proven P4PP programs
- Outcome funders pay only if measurable, audited impact achieved against pre-determined guidelines
- Pay for Patient Performance is funded entirely by the SPV, de-risking patient underperformance for public payers
- Intermediary and service provider will receive a share of the outcome payments, ensuring alignment with patient performance
- Patient treatment and distribution of payments occurs on existing infrastructure, ensuring that SPV funds directly target patient behavior

Illustrative Cash Flow (Subject to Fund Performance)



Financial Instrument, Cash Flows, and Fees

RRF DC SPV size: \$15.0 million, based on the lowest level of cumulative operating cash flows and a four month working capital buffer.

Capital structure

- Debt Tranche:** The debt tranche shall consist of \$9.0 million of senior notes and is targeted toward institutional investors, trusts, and high net worth individuals who desire priority in repayment with a competitive return profile. The senior notes will be issued at par with a 6.0% coupon, paid semi-annually and will also receive 2.0% of program proceeds. Principal shall begin to amortize when outcome payments begin and is anticipated to be paid down fully in five years.
- Equity Tranche:** Funds shall be drawn from capital commitments from investors and will be invested in the equity tranche of the SPV. Target investors are institutional investors, foundations, trusts, and high net worth individuals willing to exchange a junior position in the capital structure and a longer investment horizon for higher

potential return. The draw for the DC pilot program would be \$6.0 million and the target IRR for the DC SPV will be 13-16%.

Use of Funds

Funds will be invested into an SPV managed by Red Ribbon Capital, ("RRC") a firm who serves as an intermediary organization on pay for success projects. RRC will work with FHI360 who will oversee distribution of the patient payments. The SPV is also responsible for debt service, payment of a management fee to RRC, and contract payments to service and sub-service providers.

Fees

Transaction fees, including fees for investment bankers, lawyers, and accountants, will be paid at close and are assumed to be 3.0% due to the size of the initial issuance. Annual management fees of 2.5% will be paid to RRC to cover operating expenditures and service fees to the service and sub-service providers. Success payments of 10.0% of total outcome payments would be shared by RRC and the service provider to incentivize achievement of viral suppression targets.

Due diligence

We conducted primary research with public health experts specializing in HIV care to discuss program feasibility and implementation. Moving forward, the selection of the service provider, the target region and pool of investors will be key to ensure incentive alignment and deploy capital in the most risk efficient manner.

| | Risks | Mitigation Strategy |
|-----------------|--|---|
| Investors | Program unable to influence outcomes | Prior studies have proved effectiveness of P4PP programs to modify patient behavior |
| | Underlying risk/return profile of investment | Feasibility study and in-depth modeling demonstrates high chance of success of desired social and financial |
| Patients | Biased Participant selection | Selection criteria based on income and geography, unrelated to HIV plasma count |
| | Risk of patient drop-out | Incentives aligned to the HIV care continuum to incentivize patient retention |
| Outcome Funders | Working only with "low hanging fruit" | Increasing baseline viral suppression target on a step-function to expand level of impact over time |
| | Cash flow time frame | Private capital funds P4PP program, de-risking funding of outcomes |

Future Addressable Markets

The RRF model could be easily adapted to markets in which viral suppression is low. We have identified several target urban areas in the United States in which this model could successfully influence patient behavior. The RRF model is aligned with critical areas of focus of the Federal National HIV/AIDS Strategy and is well adapted for the Federal Government's shift toward outcomes based funding initiatives. This alignment creates the opportunity for the RRF model to be deployed across the United States. Future fundraising rounds will initially focus on HIV treatment in the United States, but the model can also be expanded to target international geographies and other chronically manageable diseases in the United States such as diabetes.

| | HIV+ Population | Current % Viral Suppression | Potential Savings to Healthcare Payers (\$mm) |
|-----------------|-----------------|-----------------------------|---|
| New York City | 115,000 | 49% | \$3,900 |
| Philadelphia | 30,000 | 46% | \$1,000 |
| Atlanta | 27,000 | 39% | \$900 |
| Miami | 26,000 | 28% | \$900 |
| Chicago | 23,000 | 40% | \$800 |
| Houston | 23,000 | 46% | \$800 |
| Washington D.C. | 16,000 | 47% | \$500 |
| Dallas | 16,000 | 43% | \$500 |
| Baltimore | 13,000 | 45% | \$400 |
| Total | 289,000 | | \$9,700 |

Achieving a **75% rate of viral suppression** in these cities could result in **\$9.7 billion** in potential healthcare savings

Sources: (i) "DC HAHSTA Annual Report 2014". DC Department of Health. (ii) "Financing HIV/AIDS Care: A Quilt With Many Holes". Henry J Kaiser Foundation. (iii) "Viral suppression after 12 months of antiretroviral therapy in low- and middle-income countries: a systematic review". (iv) World Health Organization. "HIV/AIDS Care Continuum". AIDS.gov. (v) "Africa – West and Central". UN AIDS Country Data. 2015. (vi) "HIV/AIDS in the Greater Washington Region". Washington AIDS Partnership. 2015. (vii) "90-90-90 An ambitious treatment target to help end the AIDS epidemic". UN AIDS. 2014. (viii) National HIV/AIDS Strategy for the United States– Updated to 2020. The White House Washington.