Health Net Access, Inc.

(A Wholly Owned Subsidiary of Health Net, Inc.)

Financial Statements as of December 31, 2014 and 2013, and for the Year Ended December 31, 2014, and for the Period From October 1, 2013 (Start of Operations) to December 31, 2013, and Independent Auditors' Report

HEALTH NET ACCESS, INC.
(A Wholly Owned Subsidiary of Health Net, Inc.)

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Stockholder of
Health Net Access, Inc.
Tempe, Arizona

We have audited the accompanying financial statements of Health Net Access, Inc. (the "Company") (a wholly owned subsidiary of Health Net, Inc.), which comprise the balance sheets as of December 31, 2014 and 2013, and the related statements of operations, stockholder's equity, and cash flows for the year ended December 31, 2014, and for the period from October 1, 2013 (start of operations) to December 31, 2013, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2014 and 2013, and the results of its operations and its cash flows for the year ended December 31, 2014, and for the period from October 1, 2013 (start of operations) to December 31, 2013, in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP

April 24, 2015

HEALTH NET ACCESS, INC.
(A Wholly Owned Subsidiary of Health Net, Inc.)

BALANCE SHEETS
AS OF DECEMBER 31, 2014 AND 2013

	2014	2013
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 103,801,471	$ 7,589,386
Capitation/supplement/risk adjustment receivable	862,366	69,666
Reinsurance receivable	2,000,772	-
Reconciliation receivables	8,085,135	-
Provider receivables, net of allowance (2014-$66,250, 2013-$1,344)	282,520	32,256
Pharmaceutical rebates receivable	571,957	4,089
Income taxes receivable from affiliate	3,848,146	132,154
Deferred taxes	3,089,748	6,549
Prepaid and other assets	712,426	23,391
Current due from affiliates	433,762	-
Total current assets	123,688,303	7,857,491
Prospective reconciliation receivable	3,343,194	323,461
Newly eligible adults reconciliation receivable	1,740,212	-
Total Assets	$ 128,771,709	$ 8,180,952
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Medical claims payable	$ 69,807,144	$ 1,650,645
Premium deficiency reserve	7,110,159	-
Reconciliation payables	33,844,787	-
Current due to affiliates	2,196,045	457,768
Unrecognized tax benefit liability	364,942	-
Performance bond payable	45,000	-
Total current liabilities	113,368,077	2,108,413
Prior period coverage reconciliation payable	2,756,797	219,551
Payment reform initiative liability	467,054	-
Total Liabilities	116,591,928	2,327,964
Commitments and contingencies (Note 8)		
Stockholders' Equity:		
Common stock (no par value, 100 shares authorized, issued and outstanding)	-	-
Additional paid-in capital	21,500,000	7,500,000
Retained deficit	(9,320,219)	(1,647,012)
Total Stockholders' Equity	12,179,781	5,852,988
Total Liabilities and Stockholders' Equity	$ 128,771,709	$ 8,180,952

See accompanying notes to financial statements.

HEALTH NET ACCESS, INC.
(A Wholly Owned Subsidiary of Health Net, Inc.)

STATEMENTS OF OPERATIONS
FOR THE YEAR ENDED DECEMBER 31, 2014, AND FOR THE PERIOD FROM OCTOBER 1, 2013 (START OF OPERATIONS) TO DECEMBER 31, 2013

	Year Ended December 31, 2014	Period From October 1, 2013 (Start of Operations) to December 31, 2013
REVENUES:		
Health services premiums		
Prospective capitation	$ 162,916,412	$ 1,737,058
Prior period coverage capitation	85,159,165	855,031
Delivery supplement	9,247,347	122,175
Newly eligible adults reconciliation settlement	(1,296,251)	-
Prospective tiered reconciliation settlement	9,852,266	323,461
Prior period coverage settlement	(33,345,570)	(219,551)
Health insurer fee revenue	61,219	-
Total health services premiums	232,594,588	2,818,174
Investment and other income	1,156	5
Total revenues	232,595,744	2,818,179
EXPENSES:		
Health care services		
Hospitalization	78,093,485	1,346,597
Medical compensation	54,584,064	527,041
Other medical	87,198,510	734,406
Increase in premium deficiency reserve	7,110,159	-
Less reinsurance	(2,717,748)	-
Total health care services, net of reinsurance	224,268,470	2,608,044
Premium tax	4,645,905	54,412
Administrative	15,318,046	1,426,411
Interest	133,369	4
Total expenses	244,365,790	4,088,871
LOSS BEFORE INCOME TAX BENEFIT	(11,770,046)	(1,270,692)
INCOME TAX BENEFIT	(4,096,839)	(444,742)
NET LOSS	$ (7,673,207)	$ (825,950)

See accompanying notes to financial statements.

HEALTH NET ACCESS, INC.
(A Wholly Owned Subsidiary of Health Net, Inc.)

STATEMENTS OF STOCKHOLDER'S EQUITY
FOR THE YEAR ENDED DECEMBER 31, 2014, AND FOR THE PERIOD FROM OCTOBER 1, 2013 (START OF OPERATIONS) TO DECEMBER 31, 2013

	Common Stock	Additional Paid-In Capital	Retained Deficit	Total Stockholder's Equity
BALANCE—October 1, 2013 (start of operations)	$ -	$ 7,500,000	$ (821,062)	$ 6,678,938
Net loss			(825,950)	(825,950)
BALANCE—December 31, 2013	-	7,500,000	(1,647,012)	5,852,988
Net loss			(7,673,207)	(7,673,207)
Paid-in capital contributions from Parent Company		14,000,000		14,000,000
BALANCE—December 31, 2014	$ -	$ 21,500,000	$ (9,320,219)	$ 12,179,781

See accompanying notes to financial statements.

HEALTH NET ACCESS, INC.
(A Wholly Owned Subsidiary of Health Net, Inc.)

STATEMENTS OF CASH FLOWS
FOR THE YEAR ENDED DECEMBER 31, 2014, AND FOR THE PERIOD FROM OCTOBER 1, 2013 (START OF OPERATIONS) TO DECEMBER 31, 2013

	Year Ended December 31, 2014	Period From October 1, 2013 (Start of Operations) to December 31, 2013
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net loss	$ (7,673,207)	$ (825,950)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Provision for deferred federal income taxes	(3,083,199)	(6,549)
Change in assets and liabilities:		
Capitation/supplement/risk adjustment receivable	(792,700)	(69,666)
Reinsurance receivable	(2,000,772)	-
Reconciliation receivables and payables	23,536,953	(103,910)
Provider receivables	(250,264)	(32,256)
Pharmaceutical rebates receivable	(567,868)	(4,089)
Income taxes receivable from affiliate	(3,715,992)	30,176
Prepaid and other assets	(689,035)	(23,391)
Current due from or to affiliates	1,304,515	250,040
Medical claims payable	68,156,499	1,650,645
Premium deficiency reserve	7,110,159	-
Unrecognized tax benefit liability	364,942	-
Performance bond payable	45,000	-
Payment reform initiative liability	467,054	-
Net cash provided by operating activities	82,212,085	865,050
CASH FLOWS FROM FINANCING ACTIVITIES:		
Cash paid-in capital from Parent Company	14,000,000	-
Net cash provided by financing activities	14,000,000	-
NET INCREASE IN CASH AND CASH EQUIVALENTS	96,212,085	865,050
CASH AND CASH EQUIVALENTS—Beginning of period	7,589,386	6,724,336
CASH AND CASH EQUIVALENTS—End of period	$ 103,801,471	$ 7,589,386

See accompanying notes to financial statements.

1. DESCRIPTION OF BUSINESS AND SIGNIFICANT ACCOUNTING POLICIES

Organization—Health Net Access, Inc. (the "Company" or the "Plan") was incorporated in Arizona on April 23, 2013, and commenced operations on October 1, 2013. The Company is a wholly owned subsidiary of Health Net, Inc. ("HNI" or the "Parent Company"), a corporation incorporated in Delaware.

The Company is regulated by the Arizona Health Care Cost Containment System ("AHCCCS"), Arizona's Medicaid program. AHCCCS is approved by the Secretary of Health and Human Services and the Centers for Medicare and Medicaid Services, as a Section 1115, of the Social Security Act, Waiver Demonstration Program, which gives Arizona additional flexibility to design and improve its program, while still receiving Federal Medicaid expenditures.

Effective October 1, 2013, the Company became a contractor for AHCCCS, by entering into a prepaid capitated contract, pursuant to Arizona Revised Statutes Title 36 Chapter 29, and thereby started to administer acute health care services to qualified Medicaid members in Maricopa County, Arizona, in accordance with AHCCCS statute and rules, and federal law and regulations. The initial term of the prepaid capitated contract is three years, expiring on September 30, 2016. However, at the discretion of AHCCCS, the contract can be extended annually, for two additional years. See Note 10 (Subsequent Events).

Significant Accounting Policies:

Basis of Presentation—The accompanying financial statements are prepared on the basis of accounting principles generally accepted in the United States of America ("GAAP").

AHCCCS provided a waiver from the audit requirement for 2013, on the condition that the Company file audited financial statements, as of December 31, 2013, and for the period from October 1, 2013 (start of operations) to December 31, 2013, with the audited financial statements as of December 31, 2014 and for the year then ended. The Company's quarterly filings to AHCCCS did not include the period prior to October 1, 2013 (start of operations), because the contract with AHCCCS was effective beginning on October 1, 2013, and therefore the period from April 23, 2013 (inception) to September 30, 2013 is not included in the accompanying financial statements.

The accompanying financial statements, which present the balance sheets, statements of operations, changes in stockholder's equity, and cash flows for the Company, may not necessarily be indicative of the conditions that would have existed or the results of operations if the Company had been operated as an unaffiliated company. Portions of certain income and expenses represent allocations made from affiliated companies applicable to shared items of the affiliated companies. See Note 6 (Related Party Transactions).

Use of Estimates—The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities through the date of the issuance of the financial statements, and the reported amounts of revenues and expenses during the reporting period. These estimates require the Company to apply complex assumptions and judgments, and often the Company must make estimates about effects of matters that are inherently uncertain and will likely change in subsequent periods. Actual results could differ from those estimates. Principal areas requiring the use of estimates include revenue recognition (including the reconciliation settlements, described below), health care services costs, including incurred but not yet reported amounts and the premium deficiency reserve, and income taxes.

Cash and Cash Equivalents—Cash equivalents include all highly liquid investments with maturity of three months or less when purchased. Cash and cash equivalents are carried at cost, which approximates fair value.

Health Services Premiums—Health services premiums include the following amounts:

Prospective capitation—Prospective capitation premiums are based on multi-year contracts with AHCCCS to provide care to Medicaid recipients.

Prior Period Coverage ("PPC") capitation—PPC capitation premiums cover eligible health care costs of members related to the period prior to their enrollment in the Plan. Such premiums are recognized upon receipt.

Delivery supplement—Delivery supplement premiums are intended to cover the costs of maternity care for deliveries during the prospective enrollment period. Such premiums are recognized in the period the delivery occurs.

Reconciliation Settlements—AHCCCS has risk sharing programs which includes reconciliation settlements, which impact health services premiums, and are due to, or from, AHCCCS, based on predetermined profit/(loss) thresholds before income tax. If the profit or loss is less than or equal to 3% of the prospective capitation revenues, then the Company's share is 100%. If the profit is between 3% and 6%, then the Company's share is 50% of the amount over 3%, for a maximum of 4.5% of total profits. If the profit is over 6%, then the Company's share of the profits over 6% is 0%, for a maximum share of 4.5% of total profits. If the losses are in excess of 3%, then the Company's share over 3% of the losses is 0%, for a maximum share of 3% of total losses. Separate reconciliations are performed for regular prospective members, PPC members, and for newly eligible adult members. PPC and newly eligible adult members are subject to different profit and loss corridors than described above (2% and 1% risk corridors, respectively, instead of 3%, and other differences). In addition, AHCCCS risk-adjusts future prospective capitation revenue to reflect the acuity of the Company's membership population.

Revenue is recognized in the month in which the related enrollees are entitled to health care services.

All of the Company's revenue is derived from Arizona, and all of the Company's revenue is derived from its Medicaid contract with AHCCCS.

Primary Care Physician ("PCP") Parity Cost Settlement—Under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), the Company must pay qualified primary care providers (and other providers specified in the ACA) fees that are no less than the Medicare fee schedule in effect for calendar years 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare conversion factor, whichever is greater, for certain services designated by specific Current Procedural Terminology codes. Since this was not

initially contemplated in the Company's capitation premium rates, AHCCCS agreed to provide additional compensation to the Company, to cover the additional payments to the providers, and the related premium taxes resulting from the additional compensation. Since the Company is not at risk for the additional payments to the providers, and the related premium taxes on the additional compensation, these amounts are reported net of the additional compensation, in the statement of operations in the audited financial statements, but are reported on a gross basis in the quarterly and annual reporting forms filed with AHCCCS, in accordance with the guidance provided by AHCCCS. See Note 9 (Reconciliation to the Annual Financial Reporting Form Filed with AHCCCS).

Health Care Services—The cost of health care services is recognized in the period in which services are provided and includes an estimate of the cost of services that have been incurred but not yet reported. Such costs include payments to primary care physicians, specialists, hospitals, outpatient care facilities, pharmaceuticals, and other medical services and the costs associated with managing the extent of such care. The Company's health care costs can also include, from time to time, remediation of certain claims as a result of periodic reviews by various regulatory agencies. The Company estimates the amount of the provision for health care service costs incurred but not reported and the unpaid loss adjustment expenses using standard actuarial methodologies based upon historical data, including the period between the date services are rendered and the date claims are received and paid, denied claim activity, expected medical cost inflation, seasonality patterns, and changes in membership. The estimates for service costs incurred but not reported are made on an accrual basis and adjusted in future periods as required. Any adjustments to the prior period estimates are included in the current period. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amounts of claims and losses paid are dependent on future developments, management is of the opinion that the recorded medical claims payable is adequate to cover such costs.

The Company contracts with various providers, including medical groups, to provide professional care to certain of its enrollees on a capitated or fixed fee per member per month basis. In addition, the Company contracts with certain hospitals to provide hospital care to enrolled members on a capitation basis. Additionally, the Company also contracts with hospitals, physicians, and other providers of health care, pursuant to discounted fee-for-service arrangements, hospital per diem arrangements, and case rate arrangements, under which providers bill the Company for each individual service provided to enrollees.

For the year ended December 31, 2014 and the quarter ended December 31, 2013, the Company paid $380,523 and $18,705, respectively, in newborn costs, incurred from the date of birth to the day before a tardy notification, for which no capitation revenue was received.

Premium Deficiency Reserve—The Company assesses the profitability of contracts for providing health care services when operating results or forecasts indicate probable future losses. Contracts are grouped in a manner consistent with the method of determining premium rates. Losses are determined by comparing anticipated premiums to the total of estimated health care related costs, less reinsurance recoveries, if any, and the cost of maintaining the contracts. Losses, if any, would be recognized in the period the loss is determined and classified as health care services expenses. The Company reported premium deficiency reserves of $7,110,159 and $0, respectively, as of December 31, 2014 and 2013.

Reinsurance—The AHCCCS risk sharing programs include reinsurance, whereby certain contract service costs incurred for a member beyond a predetermined monetary threshold, or a specific medical condition, are reimbursed. Health care services expenses are reported net of reinsurance.

Taxes Based on Premiums—The Company pays premium taxes based on premiums collected, in lieu of state income taxes. Premium tax expense totaled $4,645,905 ($4,716,054 prior to an AHCCCS reimbursement of $70,149) and $54,412 for the year ended December 31, 2014 and the quarter ended December 31, 2013, respectively. See Note 9 (Reconciliation to the Annual Financial Reporting Form Filed with AHCCCS).

Premium-based Fee on Health Insurers—The ACA mandated significant reforms to various aspects of the U.S. health insurance industry. Among other things, the ACA imposes an annual premium-based fee on health insurers (the "Health Insurer Fee") for each calendar year beginning on or after January 1, 2014 which is not deductible for federal income tax purposes and in many state jurisdictions. The health insurer fee will be levied based on a ratio of an insurer's net health insurance premiums written for the previous calendar year compared to the U.S. health insurance industry total. The Company is required to estimate a liability for its portion of the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the calendar year that it is payable. Beginning in 2014, the Company anticipates reimbursement from AHCCCS through adjusted capitation premiums, and therefore also records a receivable for these amounts.

The Company paid the federal government $39,793 for its portion of the health insurance industry fee in accordance with the ACA in September 2014.

Policy Acquisition Costs—Policy acquisition costs are those variable costs that relate to the acquisition of new and renewal health insurance business. For the year ended December 31, 2014 and the quarter ended December 31, 2013, the Company recorded marketing costs of $20,199 and $0, respectively. The Company expenses these costs as incurred and reports policy acquisition costs as administrative expenses in the statements of operations.

Reserves for Contingent Liabilities—In the course of the Company's operations, the Company is involved on a routine basis in various disputes with members, health care providers, and other entities, as well as audits by government agencies and elected officials that relate to the Company's services and/or business practices that expose the Company to potential losses.

The Company recognizes an estimated loss, which may represent damages, assessment of regulatory fines or penalties, settlement costs, future legal expenses, or a combination of the foregoing, as appropriate, from such loss contingencies when it is both probable that a loss will be incurred and that the amount of the loss can be reasonably estimated. The Company's loss estimates are based in part on an analysis of potential results, the stage of the proceedings, consultation with outside counsel, and any other relevant information available.

Payment Reform/Shared Savings—To encourage Contractors in quality improvement as it relates to health outcomes and cost savings, AHCCCS will make payments to Contractors based on 1) relative Contractor performance rank among all Contractors and 2) relative Contractor performance to minimum standards. Payment funding is derived from the 1% withhold of gross capitated rates. The Company accrues amounts whenever a standard quality measure event occurs.

Income Taxes—The Company records deferred tax assets and liabilities based on differences between the book and tax bases of assets and liabilities. The deferred tax assets and liabilities are calculated by applying enacted tax rates and laws to taxable years in which such differences are expected to reverse. The Company establishes a valuation allowance in accordance with the provisions of the Income Taxes Topic of Financial Accounting Standards Board ("FASB") codification. The Company continually reviews the adequacy of the valuation allowance and recognizes the benefits from the Company's deferred tax assets only when an analysis of both positive and negative factors indicate that it is more likely than not that the benefits will be realized.

The Company files tax returns in many tax jurisdictions. Often, application of tax rules within the various jurisdictions is subject to differing interpretation. Despite the Company's belief that its tax return positions are fully supportable, the Company believes that it is probable certain positions will be challenged by taxing authorities, and the Company may not prevail on the positions as filed. Accordingly, the Company maintains a liability for the estimated amount of contingent tax challenges by taxing authorities upon examination. An analysis is performed of the amount at which each tax position meets a "more likely than not" standard for sustainability upon examination by taxing authorities. Only tax benefit amounts meeting or exceeding this standard will be reflected in the tax expense and deferred tax asset balances. Any differences between the amounts of tax benefits reported on tax returns and tax benefits reported in the financial statements will be recorded as a liability for unrecognized tax benefits. The liability for unrecognized tax benefits is reported separately from deferred tax assets and liabilities and is classified as current or noncurrent based upon the expected period of payment. See Note 4 (Income Taxes).

Concentrations of Credit Risk—Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash equivalents, and capitation receivable. All cash equivalents are managed within established guidelines, which provide diversity among issuers. Concentrations of credit risk with respect to capitation receivable is high due to the single payer comprising the Company's customer base. However, since the single payer is the state government, the risk is mitigated.

All of the Company's Medicaid revenue is derived in Arizona, and all of the Company's revenue is derived from its contract with AHCCCS.

Fair Value of Financial Instruments—The estimated fair value amounts of cash equivalents have been determined by using available market information and appropriate valuation methodologies. The carrying amounts of cash equivalents approximate fair value due to the short maturity of those instruments.

2. INVESTMENTS AVAILABLE-FOR-SALE

The Company had no investments available-for-sale as of December 31, 2014 and 2013.

3. MEDICAL CLAIMS PAYABLE AND UNPAID CLAIMS ADJUSTMENT EXPENSES

The activity in the medical claims payable and unpaid claims adjustment expenses is summarized as follows:

	For the Year Ended December 31, 2014	For the Period From October 1, 2013 (Start of Operations) to December 31, 2013
Medical claims payable—beginning balance	$ 1,650,645	$ -
Amount incurred related to:		
Current year	214,279,511	2,591,615
Prior periods	2,878,800	16,429
Total incurred	217,158,311	2,608,044
Amount paid related to:		
Current year	144,641,671	957,399
Prior periods	4,360,141	
Total paid	149,001,812	957,399
Medical claims payable—December 31	$ 69,807,144	$ 1,650,645

For the year ended December 31, 2014 and the quarter ended December 31, 2013, the premium deficiency reserve of $7,110,159 and $0, respectively, was not included in the table above, but was included in the total health care services expenses on the statements of operations.

Amounts incurred related to prior periods represents the change in medical claims payable attributable to the difference between the original estimate of incurred claims for prior periods and the revised estimate. In developing the revised estimate, there have been no changes in the approach used to determine the key actuarial assumptions, which are the completion factor and medical cost trend. Medical claims payable are estimated under actuarial standards of practice and GAAP. The majority of the medical claims payable balance held at each quarter-end is associated with the most recent months' incurred services because these are the services for which the fewest claims have been paid. The degree of uncertainty in the estimates of incurred claims is greater for the most recent months' incurred services. Revised estimates for prior periods are determined in each quarter based on the most recent updates of paid claims for prior periods.

As of December 31, 2014 and 2013, amounts incurred related to prior periods were estimated to be higher than originally estimated by $2,878,800 and $16,429, respectively. The majority of these amounts were due to adjustments to the medical claims payable that related to variables and uncertainties associated with the Company's assumptions. Actual claim experience was less favorable than the Company's estimate.

4. INCOME TAXES

The Company is included in the consolidated federal tax returns of HNI. Under a written agreement, HNI collects from, or refunds to, its subsidiaries, the amount of taxes or benefits determined as if the subsidiaries filed separate returns. Intercompany tax balances are settled monthly.

Significant components for income tax benefit are as follows:

	For the Year Ended December 31, 2014	For the Period From October 1, 2013 (Start of Operations) to December 31, 2013
Current federal	$ (1,013,640)	$ (438,193)
Deferred federal	(3,083,199)	(6,549)
Total income tax benefit	$ (4,096,839)	$ (444,742)

A reconciliation of the federal income tax rate and the effective income tax rate is as follows:

	For the Year Ended December 31, 2014	For the Period From October 1, 2013 (Start of Operations) to December 31, 2013
Income taxes at the federal rate	$ (4,119,517)	$ (444,742)
Other—net	22,678	-
Income taxes at the effective rate	$ (4,096,839)	$ (444,742)

Significant components of the Company's deferred tax assets and liabilities are as follows:

	For the Year Ended December 31, 2014	For the Period From October 1, 2013 (Start of Operations) to December 31, 2013
Deferred tax assets:		
Accrued liabilities	$ 3,066,560	$ 6,079
Allowance for provider receivable	23,188	470
Total deferred tax assets	$ 3,089,748	$ 6,549

As of December 31, 2014 and 2013, the Company had no federal net operating loss carryforwards. Accordingly, no valuation allowances have been provided to account for the potential limitations on utilization of tax benefits.

A reconciliation of the beginning and ending amount of unrecognized tax benefits, exclusive of related interest, is as follows:

	For the Year Ended December 31, 2014	For the Period From October 1, 2013 (Start of Operations) to December 31, 2013
Gross unrecognized tax benefits beginning of year	$ -	$ -
Increases in unrecognized tax benefits related to current year	364,942	-
Gross unrecognized tax benefits end of year	$ 364,942	$ -

The current and long-term portions of the unrecognized tax benefit liability are as follows as of December 31, 2014:

	Current	Long-Term	Total
Gross unrecognized tax benefits	$ -	$ 364,942	$ 364,942
Interest	-	-	-
Total unrecognized tax benefits including interest	$ -	$ 364,942	$ 364,942

Of the $364,942 total liability for unrecognized tax benefits as of December 31, 2014, none would, if recognized, affect the Company's effective tax rate. The entire $364,942 would result in adjustments to deferred tax assets.

The Company recognized interest and any applicable penalties, which could be assessed related to unrecognized tax benefits, in the income tax provision. Accrued interest and penalties are included within the related tax liability in the balance sheet. During 2014 and 2013, $0 of interest was recorded as an income tax expense. The Company reported interest accruals of $0 as of December 31, 2014 and 2013. Provision expense and accruals for tax-related penalties were immaterial in all reporting periods.

The Company files tax returns in the federal as well as several state tax jurisdictions as part of a consolidated group. As of December 31, 2014, tax years subject to examination in the federal jurisdiction are 2010 and forward. The most significant state tax jurisdiction for the consolidated group is California, and tax years subject to examination by that jurisdiction are 2010 and forward. Presently, the consolidated group is under examination as a large taxpayer by the Internal Revenue Service covering tax year 2010 and forward, and in addition, the consolidated group is undergoing examination by various state taxing authorities. The Company does not believe that any ongoing examination will have a material impact on its balance sheets and statements of operations. In the next twelve months, the Company does not believe that its unrecognized tax benefits will change significantly due to the potential resolution of tax matters.

5. EMPLOYEE BENEFIT PLANS

The Company does not have any employees. The Company has no direct 401(k), retirement plan, or postretirement plan expenses. However, employees of affiliates provide services to the Company. Compensation expense, including 401(k) plan, retirement plan, or postretirement plan expenses of $104,406 and $1,336 were allocated to the Company from affiliates, and reported as part of selling, general and administrative expenses for the year ended December 31, 2014 and the quarter ended December 31, 2013, respectively.

Affiliates of the Company participate in a defined contribution retirement plan sponsored by HNI, that is intended to qualify under Sections 401(a) and 401(k) of the Internal Revenue Code of 1986, as amended (the "Code"). Participation in the plan is available to substantially all affiliate employees who meet certain eligibility requirements and elect to participate. Affiliate employees may contribute up to the maximum limits allowed under the Code, with the affiliate Company's contributions based on matching or other formulas.

6. RELATED PARTY TRANSACTIONS

The Company relies on affiliate services to conduct its business in order to achieve cost savings. The Company does nevertheless exercise ultimate control over its assets and operations and retains the ultimate authority and responsibility regarding its powers, duties, and responsibilities.

The Company is a party to several administrative service agreements with HNI and its affiliates, which authorize certain services to be performed on behalf of the Company and vice versa. The entities performing the services are compensated according to the terms set forth in the agreements. Expenses incurred by the Company under these agreements totaled $15,098,336 and $1,423,912, respectively, for the year ended December 31, 2014 and the quarter ended December 31, 2013, and are included in either health care services expenses or administrative expenses. Balances associated with these agreements are settled within 30 days in the normal course of business.

Pursuant to Claims Administration Services Agreements with Health Net Pharmaceutical Services ("HNPS"), the Company receives prescription drug claims administration, formulary management, and pharmaceutical rebate processing services in exchange for an administrative fee. The administrative fee is settled within 30 days in the normal course of business. Prior to the issuance of checks for pharmaceutical claim payments, the Company remits cash to HNPS to fund the claim payments. Pharmaceutical rebates are remitted by HNPS to the Company, as they are collected from the drug manufacturers.

The Company's significant transactions related to its agreements with HNPS are as follows:

	For the Year Ended December 31, 2014	For the Period From October 1, 2013 (Start of Operations) to December 31, 2013
HNPS claims administrative expenses	$ 427,643	$ 96,275
Funds transferred for claim payments	19,633,200	95,964
Pharmaceutical rebates recognized	662,642	4,089

The Company received cash paid-in capital contributions from its Parent Company of $14,000,000 in 2014, and $7,500,000 in 2013 (prior to the start of operations). See Note 10 (Subsequent Events) for an additional paid-in capital contribution in 2015.

See Note 4 (Income Taxes) for taxes paid to or received from an affiliate.

7. REGULATORY REQUIREMENTS

Regulatory Requirements—The Company must comply with AHCCCS established financial viability standards, for the Current Ratio, Equity Per Member, Contract Year To Date Medical Expense Ratio, and Contract Year To Date Administrative Cost Percentage.

The Current Ratio, defined as current assets divided by current liabilities, is required to be greater than 1. The Company's Current Ratio was 1.1 and 3.7, respectively, as of December 31, 2014 and 2013, and therefore the Company met this requirement.

The Equity Per Member calculation, is defined as unrestricted equity, less on-balance sheet performance bond, divided by the number of non-Six Omnibus Reconciliation Act of 1986 ("SOBRA") Family Planning Extension Services members at the end of the period. These excluded members are in a program that provides only family planning services, for a maximum of two 12-month periods, to women whose pregnancy ended, and who are not otherwise eligible to full Title XIX services, and who, while pregnant, had income at or below 150% of the Federal Poverty Level ("FPL") and children with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the children. The Equity Per Member requirement is $170 for AHCCCS contractors with enrollment less than 100,000 and $115 for AHCCCS contractors with enrollment of 100,000 or more. The Company's Equity Per Member was $154 and $1,079, respectively, as of December 31, 2014 and 2013, and therefore the Company did not meet this requirement as of December 31, 2014. However, on February 10, 2015, the Company received a cash paid-in capital contribution from its parent company of $15,000,000 that remedied the situation.

The Contract Year to Date Medical Expense Ratio, generally health care service expenses divided by all capitation and other revenues, must be at least 85%. The Company's Medical Expense ratio for the year ended December 31, 2014 and the quarter ended December 31, 2013 was 100.8% and 94.4%, respectively. The Company's Contract Year to Date Medical Expense Ratio was 118.3% and 94.4%, respectively, for the quarters ended December 31, 2014 and 2013, and therefore the Company met this requirement.

The Contract Year To Date Administrative Cost Percentage, generally defined as total administrative expenses divided by capitation and other revenue must be less than or equal to 10%. On April 14, 2014, AHCCCS granted the Company a written exception from meeting the 10% standard. Contract Year To Date Administrative Cost Percentage targets for the quarters ended March 31, 2014, June 30, 2014 and September 30, 2014 were 50%, 30%, and 20%, respectively, and the Company met those targets. The Company's Administrative Cost Percentage for the year ended December 31, 2014 and the quarter ended December 31, 2013 was 6.8% and 51.6%, respectively. The Company's Contract Year To Date Administrative Cost Percentage for the quarters ended December 31, 2014 and 2013 was 10.6% and 51.6%, respectively, and therefore the Company did not meet this requirement for the quarters ended December 31, 2014 and 2013; however, the Company did meet it for the year ended December 31, 2014, the full Contract Year ended September 30, 2014 (5.9%), and the Company expects to meet this requirement for the full Contract Year ending September 30, 2015.

Performance Bond—The Company is required to annually provide a performance bond to guarantee performance of the Company's claims payment obligations under its AHCCCS contract. The performance guarantee amount is generally based upon one month's capitation revenue, or an established amount per enrolled member. As of December 31, 2014 and 2013, the Company had a performance bond for the benefit of AHCCCS totaling $28,000,000 and $1,000,000, respectively. The

performance bond was under-funded by $(1,641,407) and $(117,035), respectively, as of December 31, 2014 and 2013. The performance bond amounts were subsequently increased to remedy the under-funded situations.

Insurance Requirement—Pursuant to the AHCCCS contract, the Company is required to maintain, and did maintain, certain minimum commercial general liability, business automobile, worker's compensation and employer's liability, and professional liability insurance coverage.

8. COMMITMENTS AND CONTINGENCIES

Overview—The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the Company's recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to that they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings, each with a wide range of potential outcomes; or result in a change of business practices. Further, there may be various levels of judicial review available to the Company in connection with any such proceeding in the event damages are awarded or a fine or penalty is assessed. As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company's financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, depending, in part, upon the Company's financial condition, results of operations, cash flow or liquidity in such period, and the Company's reputation may be adversely affected. Management believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against the Company, should not have a material adverse effect on the Company's financial condition, results of operations, cash flow and liquidity. See Note 9 (Subsequent Events).

Miscellaneous Proceedings—In the ordinary course of its business operations, the Company is subject to periodic reviews, investigations and audits by various federal and state regulatory agencies, including, without limitation, the Centers for Medicare & Medicaid Services, the AHCCCS, the Office of Civil Rights of the U.S. Department of Health and Human Services and state departments of insurance, with respect to its compliance with a wide variety of rules and regulations applicable to its business, including, without limitation, regulations applicable to government contractors, the Health Insurance Portability and Accountability Act of 1996, rules relating to pre-authorization penalties, payment of out-of-network claims, timely review of grievances and appeals, and timely and accurate payment of claims, any one of which may result in remediation of certain claims, contract termination, the loss of licensure or the right to participate in certain programs, and the assessment of regulatory fines or penalties, which could be substantial. From time to time, the Company receives subpoenas and other requests for information from, and is subject to investigations by, such regulatory agencies, as well as from state attorneys general. There also continues to be heightened review by regulatory authorities of, and increased litigation regarding, the health care industry's business practices, including, without limitation, information privacy, premium rate increases, utilization management, appeal and grievance processing, rescission of insurance coverage and claims payment practices, including under state and federal false claims laws.

In addition, in the ordinary course of its business operations, the Company is party to various other legal proceedings from time to time, which may include, without limitation, litigation arising out of its general business activities, such as contract disputes, employment litigation, wage and hour claims, including, without limitation, cases involving allegations of misclassification of employees and/or failure to pay for off-the-clock work, real estate and intellectual property claims, claims brought by members or providers seeking coverage or additional reimbursement for services allegedly rendered to its members, but which allegedly were denied, underpaid, not timely paid or not paid, and claims arising out of the acquisition or divestiture of various business units or other assets. From time to time, the Company is also subject to claims relating to the performance of contractual obligations to providers, members, employer groups and others, which may include, without limitation, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices. In addition, the Company from time to time is subject to claims relating to information security incidents and breaches, reinsurance agreements, rescission of coverage and other types of insurance coverage obligations and claims relating to the insurance industry in general. In the Company's role as a federal and state government contractor, the Company is, and may be in the future, subject to qui tam litigation brought by individuals who seek to sue on behalf of the government for violations of, among other things, state and federal false claims laws. The Company is, or may be in the future, subject to class action lawsuits brought against various managed care organizations and other class action lawsuits.

The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being, or may in the future be, sought.

***Potential Settlements*—**The Company regularly evaluates legal proceedings and regulatory matters pending against it to determine if settlement of such matters would be in the best interests of the Company and its stockholders. The costs associated with any settlement of the various legal proceedings and regulatory matters to which the Company is or may be subject from time to time could be substantial and, in certain cases, could result in a significant earnings charge in any particular quarter in which the Company enters into a settlement agreement and could have a material adverse effect on the Company's financial condition, results of operations, cash flow and/or liquidity and may affect its reputation.

9. RECONCILIATION TO THE ANNUAL FINANCIAL REPORTING FORM FILED WITH AHCCCS

AHCCCS requires the Company to report, the PCP parity cost settlement as health services premiums (revenues), the additional payments to providers as health care services expenses (medical expenses) and the related premium taxes on the PCP parity cost settlement, on its quarterly and annual financial reporting forms. However, in these audited financial statements, which are prepared in accordance with GAAP, since the Company is not at risk for the additional payments to providers and the related premium tax on the PCP parity cost settlement, these amounts are reported net of the PCP parity cost settlement. The following is the reconciliation of the audited financial statements, to the annual financial reporting form filed with AHCCCS:

	Per Audited Financial Statements	Per Annual Financial Reporting Form	Variance
Statement of Operations For the year ended December 31, 2014			
REVENUES:			
Total health services premiums	$ 232,594,588	$ 236,172,176	$ (3,577,588)
Investment and other income	1,156	1,156	-
Total Revenues	232,595,744	236,173,332	(3,577,588)
EXPENSES:			
Health care services, net of reinsurance	224,268,470	227,775,909	(3,507,439)
Premium tax	4,645,905	4,716,054	(70,149)
Administrative	15,318,046	15,318,046	-
Interest	133,369	133,369	-
Total expenses	244,365,790	247,943,378	(3,577,588)
LOSS BEFORE INCOME TAX BENEFIT	(11,770,046)	(11,770,046)	-
INCOME TAX BENEFIT	(4,096,839)	(4,096,839)	-
NET LOSS	$ (7,673,207)	$ (7,673,207)	$ -

10. SUBSEQUENT EVENTS

On February 4, 2015, the Company received a notice from AHCCCS, Division of Health Care Management ("DHCM") that stated that the Company was in violation of its contract for Acute Care Medicaid services in Maricopa County, Arizona. These violations for failure to meet contractual requirements included, among other things, deficiencies related to staffing and support services, website accessibility, provider credentialing, claims processing and grievance and appeals. As a result, DHCM imposed a monetary sanction of $200,000 to be withheld from future capitation payments, and imposed a cap on auto assignment effective February 13, 2015 until further notice. DHCM also required the Company to submit corrective action plans as specified in the notice, and stated that any failure to correct the deficiencies outlined in the notice could result in additional compliance actions, including additional sanctions up to non-renewal of the Company's one-year option to extend its contract or termination of the contract in whole or in part.

The Company's Equity Per Member was $154 as of December 31, 2014, and therefore the Company did not meet the $170 Equity Per Member requirement as of December 31, 2014. However, on February 10, 2015, the Company received a cash paid-in capital contribution from its parent company of $15,000,000 that remedied the situation.

As of December 31, 2014 and 2013, the Company had a performance bond for the benefit of AHCCCS totaling $28,000,000 and $1,000,000, respectively. The performance bond was under-funded by $(1,641,407) and $(117,035), respectively, as of December 31, 2014 and 2013. The performance bond amounts were subsequently increased to remedy the under-funded situations.

The Company has evaluated events through April 24, 2015, and has determined that there are no other subsequent events that require disclosure in these audited financial statements.

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