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ATTACHMENT A

PRE-CLOSE REGULATORY FILINGS

ENTITY	REGULATORY AUTHORITY	LICENSE HELD	FILING REQUIREMENTS	FILING PARTY	FILE/APPROVED DATE
I. CALIFORNIA					
Health Net Life Insurance Company	California Department of Insurance	Life Insurance Company	Form A (Acquisition of Control) Application requesting approval of the proposed acquisition pursuant to Ca. Ins §. 1215.2.	Centene	Filed July 31, 2015
Health Net of California, Inc.	California Department of Managed Care	Knox-Keene Full Service Health Care Service Plan	Knox-Keene Application for approval from the California Department of Managed Care of a material modification of a plan contract pursuant to Ca. H&S §1352(b).	Health Net	Filed August 10, 2015
Health Net Community Solutions, Inc.	California Department of Managed Care	Knox-Keene Full Service Health Care Service Plan	Knox-Keene Application for approval from the California Department of Managed Care of a material modification of a plan contract pursuant to Ca. H&S §1352(b).	Health Net	
Managed Health Network	California Department of Managed Care	Knox-Keene Specialized Behavioral Health Care Service Plan	Knox-Keene Application for approval from the California Department of Managed Care of a material modification of a plan contract pursuant to Ca. H&S §1352(b).	Health Net	
California Health and Wellness Plan	California Department of Managed Care	Knox-Keene Licensed Entity	Plan Amendment to update California Health and Wellness Plan's organizational chart to reflect proposed transaction.	Centene	Filed August 10, 2015
II. ARIZONA					
Health Net of Arizona, Inc.	Arizona Department of Insurance	Health Care Services Organization	Form A (Acquisition of Control) Application requesting approval of the proposed acquisition pursuant to Ariz. Ins. Code §§20-1070&481.03.	Centene	Filed July 31, 2015
Health Net Access, Inc.	Arizona Health Care Cost Containment System	Health Care Services Contractor	Notification and request for prior approval from the Arizona Health Care Cost Containment System of proposed change in ownership.	Health Net	Filed August 7, 2015

ENTITY	REGULATORY AUTHORITY	LICENSE HELD	FILING REQUIREMENTS	FILING PARTY	FILE/APPROVED DATE
III. OREGON					
Health Net Health Plan of Oregon, Inc.	Oregon Insurance Division	Health Care Services Contractor	Form A (Acquisition of Control) Application requesting approval of the proposed acquisition pursuant to Ore. Ins. Code §§750.055&732.523.	Centene	Filed July 31, 2015
			Form E (Pre-acquisition Notification) Notice regarding the potential competitive impact of the proposed acquisition in the relevant jurisdiction, pursuant to Ore. Ins. Code §§750.523&732.572 and O.A.R. §836-027-0125.	Centene	Filed July 31, 2015
IV. MISCELLANEOUS U.S. STATE REGULATORY FILINGS					
MHN Services	New Jersey Department of Banking and Insurance	Organized Delivery System	Notice of Material Modification in the form of a letter filing describing the change must be made to the New Jersey Department of Banking and Insurance pursuant to New Jersey Insurance Code § 17:48H-14.	Health Net	Filed August 10, 2015
MHN Services	Texas Department of Insurance	Third Party Administrator	Notification of Indirect Change of Control in the form of a letter filing describing the change of control must be made to the Texas Department of Insurance pursuant to Texas Insurance Code § 4151.211.	Centene	Filed August 21, 2015
Health Net Life Insurance Company	Missouri Department of Insurance	Life Insurance Company	Form E Exemption Letter stating that the proposed acquisition has no anticompetitive impact in Missouri, pursuant to Mo. Ins. Code §382.095.	Centene	Filed August 7, 2015 Exemption granted on August 20, 2015
V. CAYMAN ISLANDS					
FH Assurance Company	Cayman Islands Monetary Authority	Unrestricted Class B Insurer	Application to the Cayman Islands Monetary Authority for (public company) exemption from approval requirements.	Health Net	Filed August 6, 2015 Exemption granted on September 3, 2015
Health Net Life Reinsurance Company	Cayman Islands Monetary	Unrestricted Class B Insurer			

ENTITY	REGULATORY AUTHORITY	LICENSE HELD	FILING REQUIREMENTS	FILING PARTY	FILE/APPROVED DATE
	Authority				
VI. U.S. FEDERAL LEVEL FILING					
Centene Corporation	Federal Trade Commission and Antitrust Division of the Department of Justice		Premerger Notification and Report under Hart-Scott-Rodino Act (HSR).	Centene	Filed July 17, 2015 Termination of HSR waiting period received August 11, 2015
Health Net, Inc.				Health Net	

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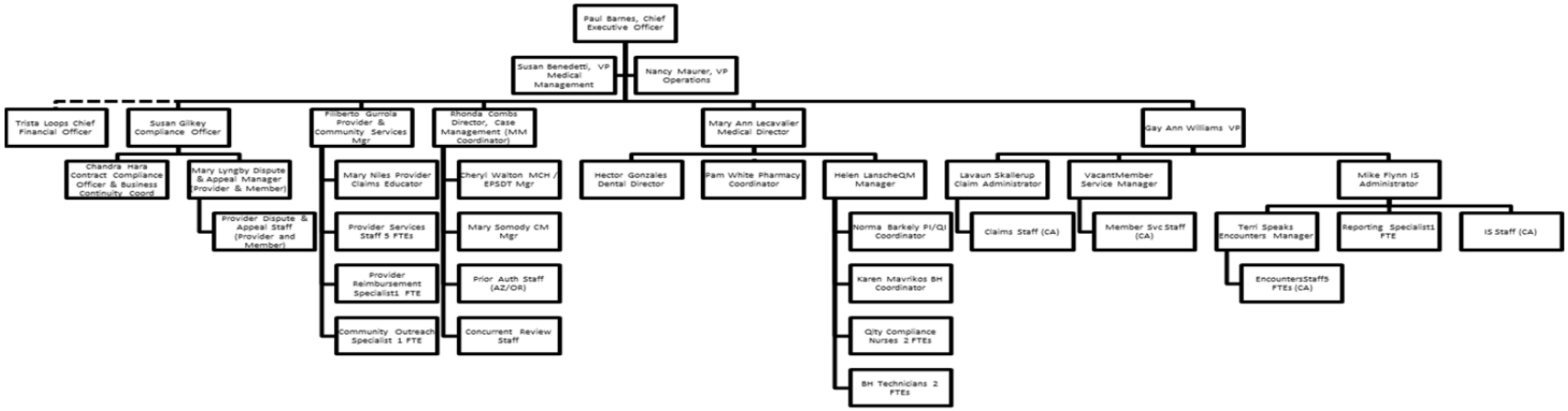
ATTACHMENT B

HEALTH NET ACCESS ORGANIZATIONAL CHART (at closing)



ATTACHMENT C

CENTENE INFORMATION SYSTEMS

Centene has over 30 years' of experience receiving, processing, paying, and reporting claims data to states partners. Nationwide, Centene's Management Information System (MIS) serves over 4.2 million Americans in publicly-funded managed care plans across 23 states. Across all affiliate health plans, Centene maintains an average auto-adjudication rate of 84.1%, with 94.69% claims paid within 14 days.

Centene processes an average of over 6.6 million medical, behavioral, and pharmacy claims a month, with a total in excess of 77 million claims in CY 2014 alone. Our success is built upon the foundation that claims processing is more than just compliance with payment rules. We see it as a critical opportunity to offer superior service to providers (ensuring a sound provider network) and members (affording them peace of mind in the financial aspects of their health care and helping ensure that person-centered care is provided). We also view the claims process as arguably the single most important data gathering aspect of the operation, since it supports the quality and utilization monitoring efforts, provider education and outreach initiatives, and will supply AHCCCS with accurate, complete, and timely encounter information.

Centene's focus on systems integration and availability is the basis for the continued ability to process claims accurately and in a timely fashion. Our Management Information Systems (MIS) include claims software components described below that are functionally rich, yet *integrated* where needed. We engineer system *availability* and *reliability* in all of the MIS components, through supporting hardware technologies such as Blade Servers, Virtualization, Clustering, Storage Area Network, and hardware, software and networking *redundancy*. We regularly test the *Business Continuity Plans (BCP)* to ensure timeliness standards are not disrupted due to staffing, weather problems, pandemic, or other unforeseen events. We maintain cross-trained claims staff who can work on Centene claims if needed in such an event, or if there is an abnormally high level of claims volume.

System Configuration. AHCCCS requirements will be hard coded within the claims processing system. Our claims processing system houses benefit coverage information as well as authorization requirements and pricing for quick systems configuration. Our claims processing system adjudicates claims through a combination of algorithms involving diagnosis and procedure codes including HCPCS data, and uses National Provider Indicator (NPI) and Tax ID numbers for provider payment.

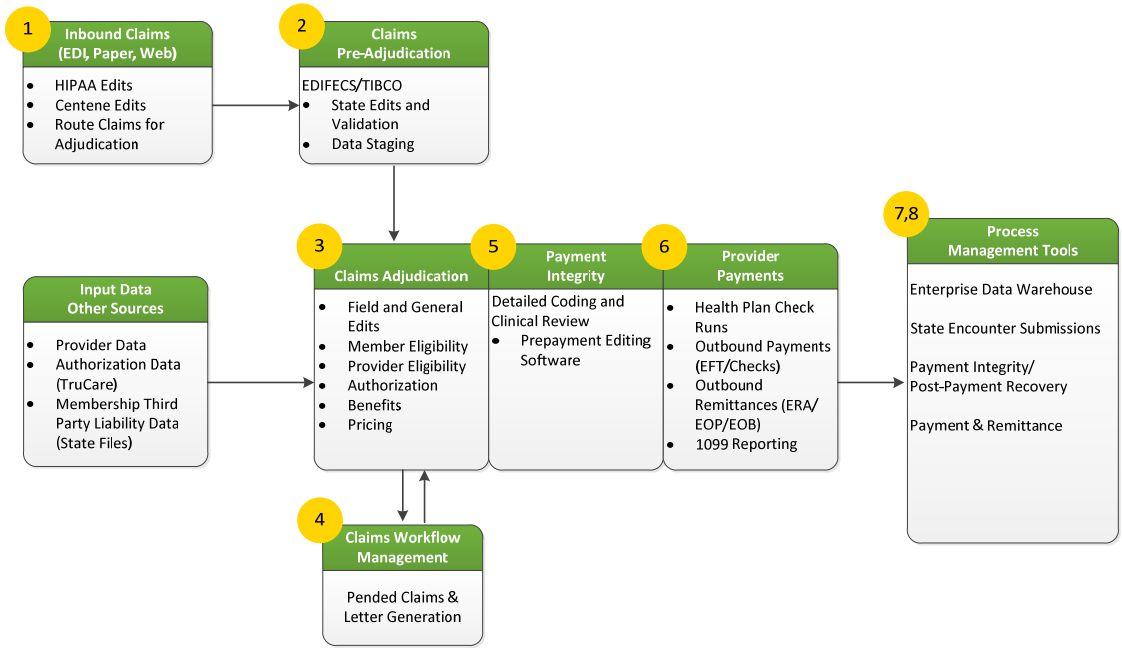
Excellence through People. We understand the dynamic nature and evolution of both healthcare and technology. Collaboration, adaptation, and change are necessary for continuous process improvement. For this reason, Centene centralizes its claims processing in the Claims Operations Centers to promote administrative cost effectiveness (with built in economies of scale), support consistency in training resulting in greater claims accuracy, facilitate efficient load balance of resources adaptable to seasonal claim volume fluctuations, and promote career path opportunities for staff. Centene's claims processing unit is an agile organization equipped with over 30 years of claims expertise, with an average of 12+ years of claims experience per claims processor, and best-in-class technologies ready to meet the specific needs of Arizona and AHCCCS.

Backed By Local Expertise and Support. Our centralized claims processing unit will be supported by Centene's dedicated team of claims processing staff, including a Claims Manager, who will be trained in Arizona- specific rules for claims and encounters processing and dedicated to Centene members and providers. Centene's claims processing staff will serve as the primary coordinator of claims activities between Health Net Access and the Claims Operations Center, and provide critical feedback on claim configuration and encounter reporting. This collaborative approach enables us to maintain the highest levels of service by processing and paying claims to provider satisfaction and delivery of accurate and timely encounter submissions. This unique unit will conduct a variety of tasks to supplement the centralized processing such as one-on-one provider trainings on submission requirements and targeted claims audits following implementation of new programs or major state reimbursement rate changes, both to ensure complete compliance with requirements and to support provider education.

Claims Submission, Processing, and Payment

Our MIS employs multiple, systematic data edits to ensure processing accuracy, a high claim auto-adjudication rate for timeliness and encounter data quality. Below is the claims submission, processing, payment, and review flowchart with accompanying details on the capability to process and pay provider claims in compliance with State and Federal regulations.

Claims Submission, Processing, Payment, and Review



1. ***HIPAA EDI Compliance.*** The EDIFECS XEngine (XEngine) software component of the MIS verifies HIPAA format compliance real-time, validating inbound data against ANSI Accredited Standards

Committee (ASC) X12N Companion Guides' rules for syntax and data structure, then triggering notification to trading partners and providers accordingly (ANSI TA1/999 Functional Acknowledgement).

2. ***Pre-adjudication Edits.*** Our Service Oriented Architecture (SOA) middleware maps, translates, and validates EDI and paper claims data against data in the Member Relationship Management and Provider Relationship Management components of the Customer Relationship Management (CRM) system prior to adjudication, ensuring common edits, such as member, billing and rendering provider identifiers are applied. If a transaction is rejected, the middleware systematically issues an ANSI 277 Unsolicited notification citing the specific AHCCCS-approved reason(s) responsible. In the event a paper claim fails pre-adjudication edits, the middleware automatically generates and sends a letter to the submitting provider, rejecting the claim and citing the specific edit(s) responsible.

3. ***Claims Processing System*.** Once claims pass pre-adjudication edits, claims are loaded into the claims processing system, which assigns each a unique control number incorporating the Julian time stamp we affix to all claims upon receipt. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link together all available information surrounding a claim and to track the adherence to claims processing timeliness standards. Our Claims Processing System's audit trails retain snapshots of all transactions for current and historic activity. This audit function includes date span logic, historical claims tracking, and operator ID stamping as well as accommodates the setting of different audit parameters for any number of management controls. Our adjudication process is the same for both network and non-network providers. We perform *six primary steps of adjudication* that a claim must pass in logical succession to reach a "finalized" (paid or denied) status or internally pended status including:

    - Field and general edits Member data edits (e.g. eligibility for services)
    - Provider data edits (e.g. eligibility and status)
    - Prior-authorization validation when required
    - Validation that services claimed are covered
    - Pricing (including the application of Third Party Liability (TPL), provider agreements, and applicable reimbursement and timely filing rules.

4. ***Claims Workflow Management.*** Our claims workflow software manages the workflow of any pended claim in real time. If a claim pends, an electronic work item is immediately routed to an Analyst, skilled in the type of pend, for resolution and re-adjudication using the six-step process above. For example, we can route specific pend codes and research issues to the licensed clinical staff for research and determination.

5. ***Detailed Coding & Clinical Review.*** *ClaimsXten™ (CXT).* Claims passing adjudication are further analyzed by the CXT software, to determine clinical claim coding appropriateness and potentially fraudulent billing practices. CXT contains a comprehensive set of rules based on nationally-recognized coding guidelines that address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. CXT offers a recommendation that is applied to the claim when a provider's coding pattern is unsupported by a coding principle. CXT's flexible configuration tools allow us to customize edits for state specific benefit criteria and provider coding/reimbursement policies. Verisk's *HealthCare Insight™ (HCI).* HCI provides for the monitoring, detection, and denial of physician claims for Provider Preventable Events (PPEs). Additionally, we are currently integrating 3M Clinical Related Group software within the enterprise MIS to allow us to further analyze claims data for the Health Net Access Arizona population, including IP utilization, and identify PPEs using the 3M standard grouper methodology in wide use in the health industry.

6. ***Claims Payment.*** Once claims successfully pass all claim edits, claims are finalized with a status of paid or denied on the next claims payable cycle. For payment, we offer providers Electronic Remittance Advices (ERA) directly to providers, or through a clearinghouse, or through the *PaySpan* service (free to providers). We also offer providers the option of EFT electronic payment via PaySpan (also free to providers). PaySpan subscribers may also view ERAs online. Of course we also offer paper check and paper Explanations of Payment (EOP) for providers not interested in these electronic transactions. Whatever the option, we provide remittance advices within one to five business days of payment. If a claim is denied for incomplete or inaccurate information, or for any reason, the provider will receive an EOP (or ERA). The EOP or ERA clearly outlines for the provider the ACHHHS approved reason(s) for claim denial, along with instructions for correction and resubmission, if applicable.

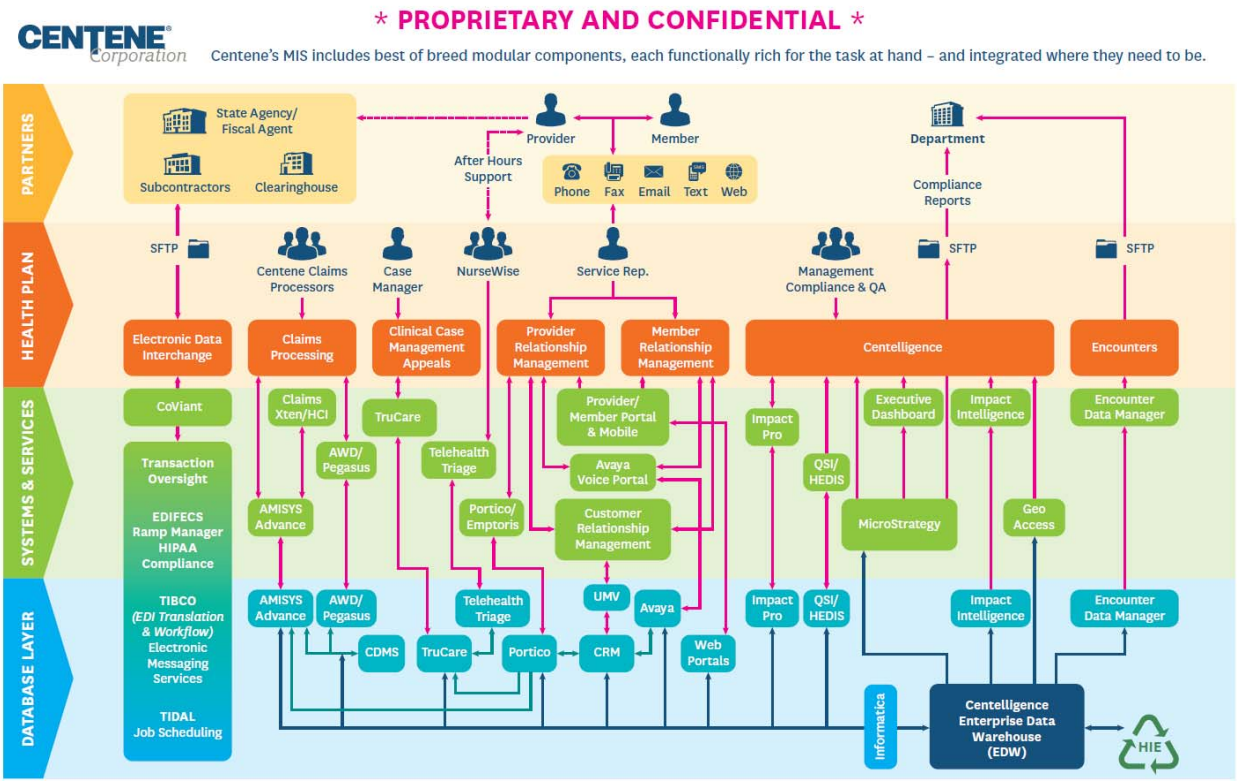
7. ***Post-Payment Recovery and Payment Integrity.*** Centene's Special Investigations Unit (SIU) utilizes the above applications to track and systematically identify billing irregularities based on industry standards (e.g., providing unapproved procedures at an ambulatory surgery center, excessive services provided in one day based on CPT time guidelines, upcoding, or excessive utilization). Our tool analyzes paid claims data and employs hundreds of edits to identify outliers that may indicate Fraud, Waste, and Abuse (FWA). Centene also conducts routine validation of claims data upon receipt, which includes checks for all applicable claims data fields. We also validate encounter data through plan focus studies, annual provider medical record reviews, provider profiling, reconciliation of encounter data detail, and targeted utilization review of specific provider claims. Centene partners with various vendors to assist with FWA identification efforts. These vendors include:

    - *Health Management Systems, Inc.* (HMS), which works to ensure claims are paid correctly, control costs associated with fraudulent claims, and reduce overall payment discrepancies, adjudication, and reimbursement expenditures. HMS helps identify and recover overpayments, detect and prevent fraud, coordination of benefits, and ensure compliance with regulations.

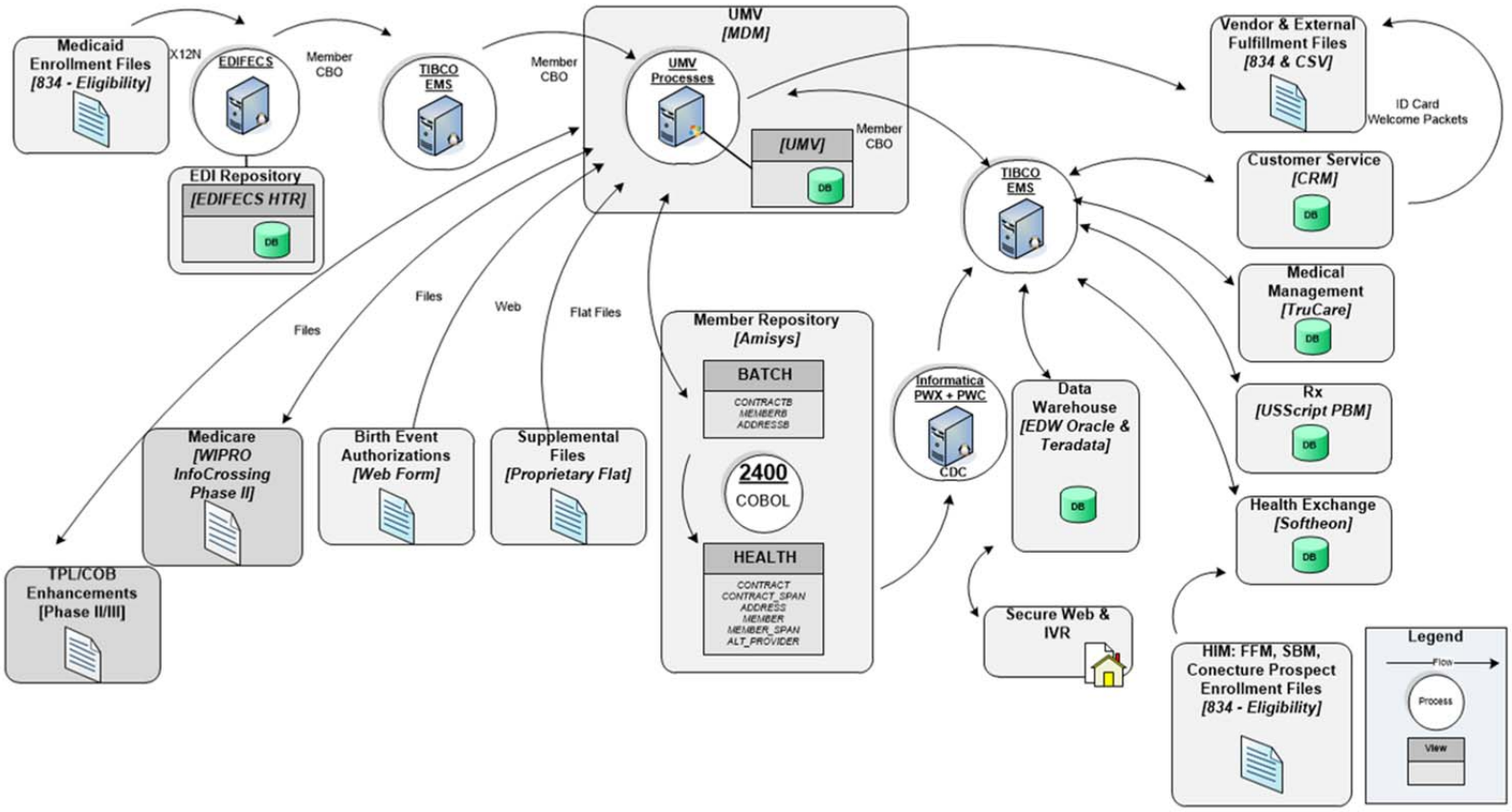
- *AIM Healthcare Services, Inc.* (AIM), which provides claims cost management services, including credit balance recoveries, retrospective FWA analysis and coordination of benefits.

- *iHealth*, which is an Inpatient Diagnosis Related Group (DRG) and Inappropriate Setting (aka Observation Audit) claim audit review process which Centene recently implemented in an effort to improve medical claims payment accuracy using a method that is acceptable and understandable to providers.

8. ***Claims Appeal Process.*** Provider Relationship Management component of CRM supports an integrated document workflow required for processing appeal requests. All paper or fax appeals are stored in the Centene Document Management System (CDMS) and indexed to the appropriate provider records in CRM, before being electronically assigned for follow up. We use the Claims Workflow Management system to track and manage the appeal throughout the process. Our local Claims Analysts and Medical Management Department work with Claims Adjustment staff in Centene's claims center to assist providers seeking (1) reconsideration of any claim, or (2) to dispute the response to such a request.



Unified Member View Integration



Provider Data and Relationship Management Systems

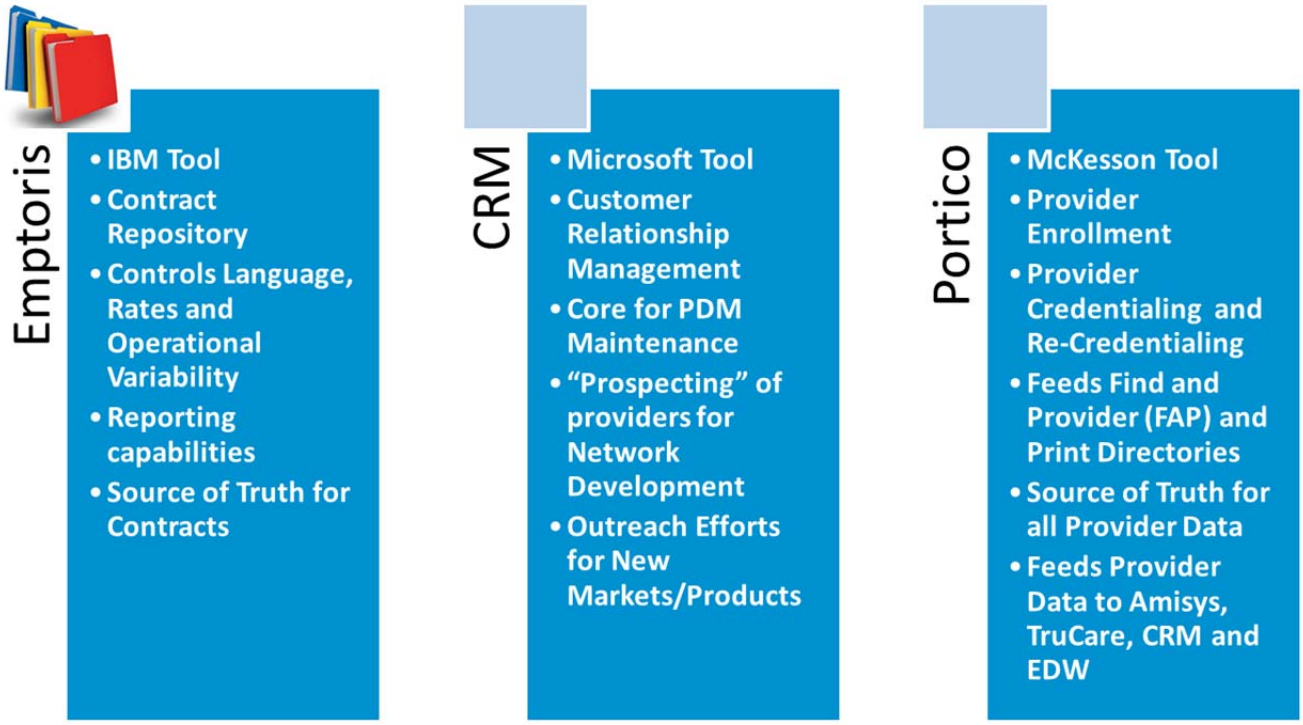
The Provider Data Management (PDM) system includes

A single relational repository for all of Centene core provider functions, including provider prospecting and recruiting; contracting; enrollment; credentialing; financial affiliation configuration; data administration; and provider directory management.

Our Provider Data Management Department enters and updates provider data in PDM, ensuring that all provider data comes from one governing source for complete data integrity.

PDM stores and indexes multiple provider numbers including Tax ID, the HIPAA National Provider ID (NPI), provider's language information, locations, office hours, etc.

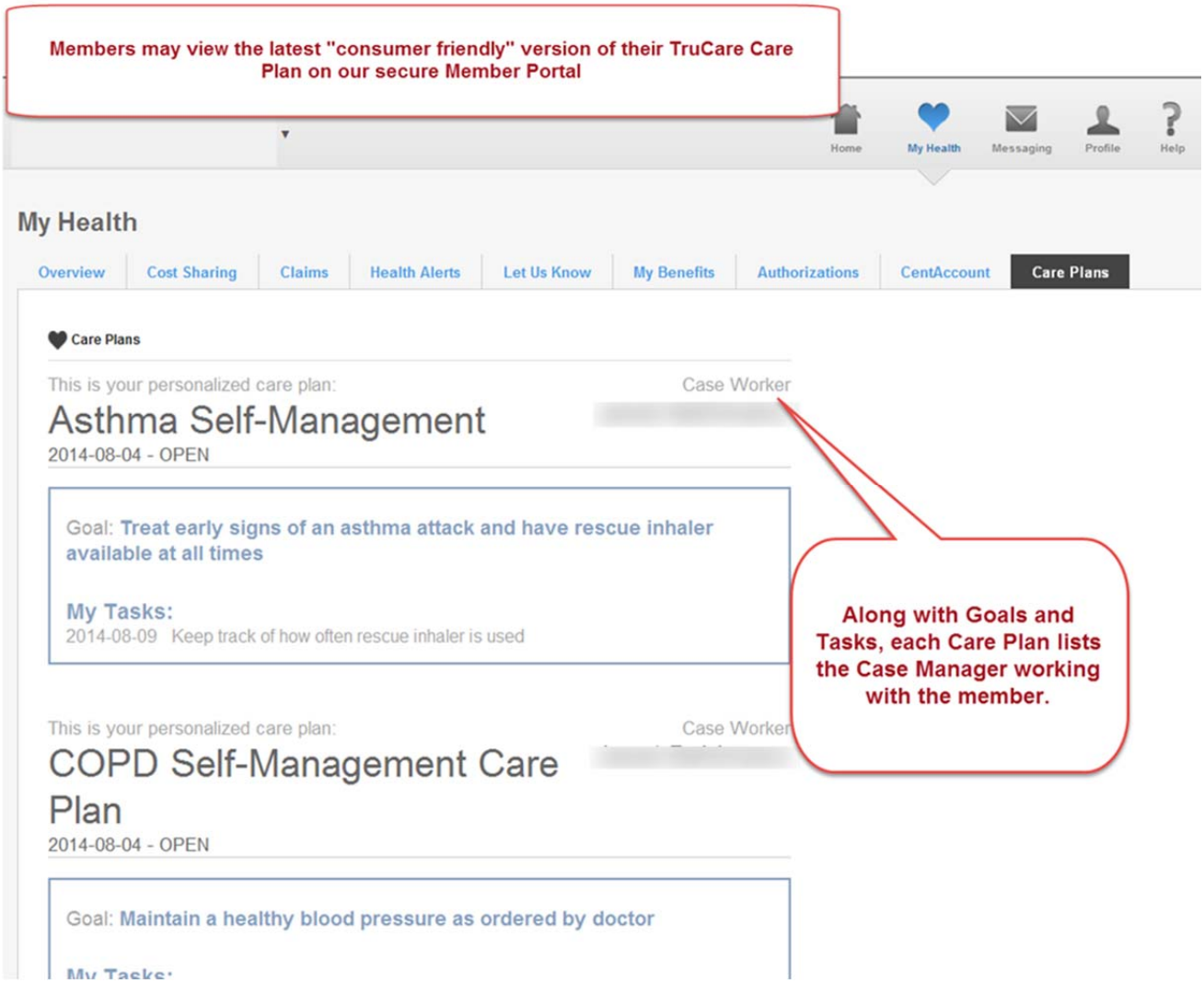
PDM is completely integrated with CRM's inquiry tracking component, enabling enterprise level call center support for provider inquiries, outbound campaigns and targeted outreach, and unified provider contact management and communications across all the venues in which providers interact with the health plans (phone, fax, email, mobile platforms or web).



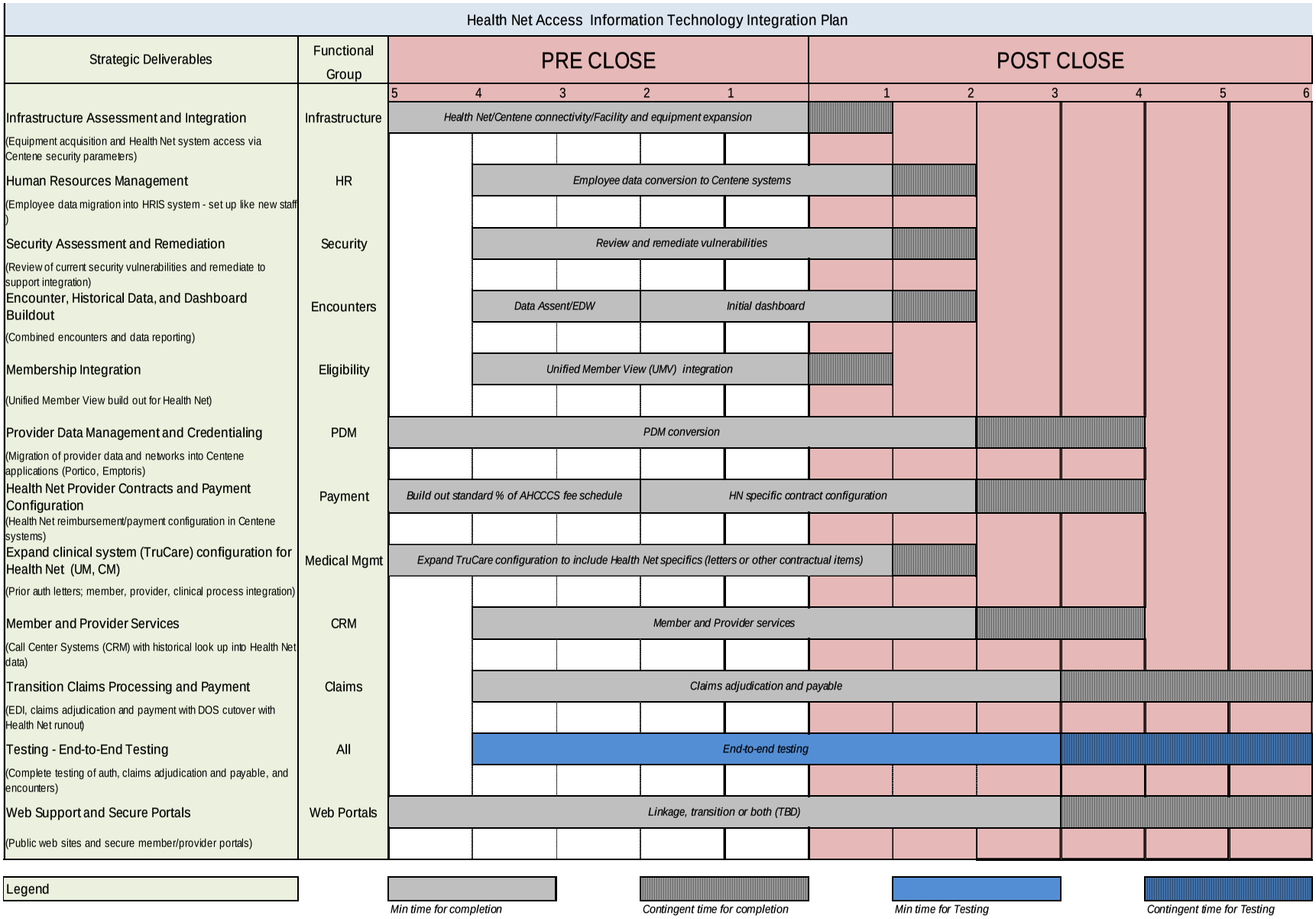
Care and Utilization Management

TruCare is the Member -centric health management platform for collaborative care coordination; and case, behavioral health, disease, and utilization management. Among other functions, TruCare houses:

- A Member's TruCare Care Plan, displays the Member's identified health problems, treatment goals and objectives, milestone dates, and progress in a well-organized online format; and is available securely to Providers and Members via the Provider and Member Portals, respectively.
- The TruCare Care Plan can be viewed within the Provider Portal– supporting collaborative care among Peach State Health Plan (PSHP) and Providers. In addition, a "consumer friendly" version of the TruCare Care Plan can be viewed on the Member Portal – further enabling members to take an active role in their health and wellness.



ATTACHMENT D
INFORMATION TECHNOLOGY INTEGRATION PLAN



Assumptions
•All target systems will be current Centene Systems (TruCare, AMISYS, EDIFECS, UMV, CRM, etc.) •This will be a Date of Service (DOS) cut over. Prior to go-live date any claims, authorizations or payments will be handled on the current Health Net system. •Provider contracts will be shared after Health Net/Centene close and will require minimum of 60 - 120 days for Configuration. •Identification of the health plan will continue to be Health Net Access.

ATTACHMENT E

INFORMATION SYSTEMS MAJOR MILESTONES

Major Milestone	**Description**	
Infrastructure Assessment and Integration	*Short*	(Equipment acquisition and HN System access via CNC Security Parameters)
	Detail	CNC is currently reviewing the infrastructure requirements to ensure that upon acquisition closure connectivity between the two companies is enabled. Specifically for AZ HNT we will be reviewing and updating the current staff equipment (PC, Telecom, etc.) to meet current CNC requirements. If new equipment is required for staff that will be included.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
Human Resources Management	*Short*	Employee Data Migration into HRIS system
	Detail	CNC will be working with the HNT HR/IT teams to determine the best course of action to accomplish seamless integration into the Centene culture. This will include the ability to access both the current HNT and CNC systems.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
Security Assessment and Remediation	*Short*	Review current security vulnerabilities and remediate to support integration
	Detail	CNC Security Teams are engaged with HNT IT/Security to ensure that upon acquisition closure any vulnerabilities established have been mitigated. At the HNT AZ level, this will include facility and full system access to ensure we continue to provide access to both CNC and existing HNT systems.
AHCCCS Involvement:	YES	Will require AHCCCS assistance in testing any change to ensure consistent access to State systems and any data exchanges.
Major Milestone	**Description**	
Encounter, Historical Data, and Dashboard Build out	*Short*	Combined Encounter and State Reporting

	Detail	HNT encounters will continue to be supported on the current HNT Encounters system for any claim with a Date-of-Service (DOS) prior to the GO-Live date (which is 3-6 months post acquisition date). Post Go-Live encounters based upon DOS will be submitted via Centene systems.
AHCCCS Involvement:	YES	HNT and CNC will require guidance from AHCCCS on the process for submitting potentially three (3) separate encounters files. These are outlined the following scenarios:
		1. Health Net: Existing HNT claims, adjustments and corrections for DOS prior to DOS cut over date will continue to be submitted in one file to AHCCCS. This will continue indefinitely.
		2. Health Net: A second HNT encounter file will be submitted with any DOS POST G0-Live to AHCCCS. This will include any claims, adjustments or corrections paid under the Centene systems however are still under the HNT branding and contract.
		3. Bridgeway: This will continue to submit Bridgeway only encounters as normal. This will NOT include any HNT claims.
Major Milestone	**Description**	
Membership Integration	*Short*	Build out Universal Member View (UMV) AZ for HNT
	Detail	Membership files will be dual loaded into both HNT and Centene's systems to support all necessary functions. We plan on drawing upon the experience of both HNT and Bridgeway current membership load and reconciliation processes.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
Provider Data Management and Credentialing	*Short*	Integration of Provider data to support authorizations, claims and payments
	Detail	Active HNT Provider data to support authorizations, claims payment, encounter processing and web access will be added to the existing product mix.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
HN Provider Contracts and Payment Configuration	*Short*	HNT Provider Reimbursement and payment configuration into Centene

	Detail	Post-acquisition close, specific provider contracts and reimbursement mythology will be reviewed and configured within Centene's Claims Payment System (AMISYS). Significant testing will occur to ensure that the timeliness and accuracy of payment is not impaired.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
Expand TruCare Configuration for HN (UM, CM, LTSS)	*Short*	Configuration of HNT Letters, Criteria and other HNT contractual items within Centene's Clinical Management System (TruCare)
	Detail	CNC will configure any and all authorization letters, clinical criteria and other contractual items within Centene's Clinical Management System. This includes update to HNT clinical policies and training material. All existing HNT clinical staff will go through extensive hands on training and certification prior to Go-Live date.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
Member and Provider Services	*Short*	Call Center Systems - CRM - Provide Historical HNT System Look-up
	Detail	HNT AZ Member and Provider Call center will be relocated post GO-Live in the AZ office. Centene's current CRM system (Microsoft Dynamics) will be configured to support the new HNT AZ business segment. All Call Post Go-Live will be recorded with the CRM system. Call Center staff will have access to the existing HNT AZ Call Center application to service any member regardless of the Service date.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
Transition Claims Processing and Payment	*Short*	EDI, Claims Adjudication and Payment, DOS Cutover
	Detail	Since Centene's systems will be used for all services based upon the DOS Go-Live, a detail work plan will be produced that outlines scenarios to "route" electronic and paper claims to existing HNT systems for DOS prior and Centene Systems post DOS. There will be no provider disruption on how they currently are submitting these service, the work to route these items will be conducted 100% behind scenes. However, the provider may receive two separate EFT/Checks based upon the DOS of the claim. This dual payment process

		will be in place for a short period.
AHCCCS Involvement:	NO	None expected.
Major Milestone	**Description**	
Testing - End-to-End Testing	*Short*	Complete testing of auth, Claims Adjudication, Payable and Encounters
	Detail	HNT and CNC plan on conducting extensive testing that includes both automate scripts and manual scripts. The end result is the "RIGHT" answer and not necessarily one that matches the current outcome.
		1. Each functional area unit testing to ensure that the discreet test scenario produces the "Right" answer not just the current answer.
		2. Business Process testing - example: Medical management testing will include receiving the authorization request (EDI, Manual or Phone), loading data into TruCare (via automation or manual entry), and producing the correct outcome to support the timely determination.
		3. End-to-End testing: This builds upon the Functional and Business Process testing. Example, the authorization received and loaded in bullet 2 above is not available to pay a claim correctly (AMISYS), support Customer Service calls (CRM), and visible via Web Portal.
AHCCCS Involvement:	YES	We would expect AHCCCS to participate in the testing especially for Encounter Submissions process.
Major Milestone	**Description**	
Web Support and Secure Portals	*Short*	Public Web Sites and Secure Member/Provider Portals
	Detail	TBD
AHCCCS Involvement:	YES	We will need approval for any changes made to HNT and CNC.

ATTACHMENT F

CENTENE CALL CENTER OPERATIONS

Member Call Center

Centene's member-centric model is designed to meet members' needs through "no wrong door" access via the member call center. Centene provides one phone number to members for access to all services. Member Services Representatives (MSRs) are trained to identify specific needs such as behavioral health needs or crisis and will warm transfer the caller to BH staff on the Care Team or the 24/7 nurse advice line, who are equipped with training, expertise and resources to support the member. Centene's Member Services staff is supported by the Customer Relationship Management (CRM) system, which supports members as well as interdepartmental Centene staff. Additionally, CRM will allow Care Teams to enter alerts if they are trying to reach a particular member. When the member calls the Member Services Line, CRM's MemberConnect feature will alert the MSRs, who will address the member's immediate issue and warm transfer the member to their Care Manager to resolve the original issue for which we had attempted to contact the member.

The mission of Member Services staff is "Determined to succeed, one call at a time" and we accomplish this through "high touch" personalized service. Centene's Member Service Department provides a critical link between members and timely, accurate information about health services. Our staff are fully committed to spend sufficient time with each caller to ensure all questions are answered and the caller is satisfied with the information provided. For example, Centene follows the best practice of not imposing limits on or monitor "talk time" for Member Services calls, as we believe each call is important and should continue for as long as is needed to ensure complete caller satisfaction. We understand the unique needs of a diverse membership and we have the processes and systems in place to ensure effective customer service.

Our Member Services Representatives (MSRs) will be available to answer calls from 7:30 a.m. to 6 p.m. Central Standard Time, Monday through Friday, excluding State declared holidays. Centene will provide a voicemail system that allows messages to be left during and after normal business hours. All messages will be retrieved and responded to within one business day of receipt. Triage and nurse advice services will be provided by the 24/7 nurse advice line affiliate and subcontractor. Our Member Service Center is located in Arizona. Establishing a regional presence not only provides local jobs, it automatically builds in greater cultural compatibility between Health Net staff and members.

When members, potential members, community based service organizations, and other public or private agencies call Centene's toll-free number, they will reach the self-service automated attendant that will immediately greet and prompt the caller to select their preferred language of English or Spanish. For members with physical, cognitive, or communication impairments, Centene uses a best practice "stay on the line" feature, which will direct callers automatically to an MSR if the caller cannot press phone keys or determine how to respond to the menu options – they will simply stay on the line for this feature to activate. After the language prompt, we also will provide certain automated options, such as for eligibility information and PCP assignment. Regardless of queue selection, all calls are

answered promptly by a live person in one minute or less, in the order received, and by the first available MSR. We provide sufficient in-bound toll-free lines to meet all performance standards.

Routing Calls. Calls normally are *not* routed *among call center staff* because all MSRs have similar comprehensive training plus information online or at their workstations to minimize the need for routing. Whenever a transfer is necessary, all call transfers are "warm" or three-way transfers, during which the MSR stays on the line and orally introduces the member to the appropriate staff person to ensure continuity and to remain in touch with the caller. Members need to use only one phone number and place only one call.

The following are key examples of routing calls to Centene staff *outside* the call center:

- MSRs have immediate access for urgent (described below) and non-urgent matters to RN and behavioral health (BH) Case Managers when clinical expertise is needed.
- After answering a member's questions, when an MSR sees a clinical *Care Gap Alert* in Customer Relationship Management (CRM) system for the member who has called Bridgway, the MSR will suggest to the member to transfer the call to a Case Manager.
- Members calling about complaints or appeals are warm transferred to a Grievance and Appeal Coordinator for assistance with the complaint and appeal process.

Escalation for Crisis Calls, Urgent Clinical Situations, and Non-Clinical Issues. MSRs will be trained to quickly identify triggers indicating a medical or behavioral health crisis call or other urgent or emergency situation in which escalation is appropriate. MSRs will listen for triggers such as key emergency words and phrases, member voice volume and tone, and other indicators of stress. When the MSR identifies triggers, they will use instant messaging to immediately obtain RN or Behavioral Health Case Manager participation in the call, and, if necessary, dial 911 for the member while keeping the member on the line. MSRs are prepared to serve all members in crisis, including members not enrolled with Centene.

MSRs will be thoroughly trained for a wide variety of call types and have the skills and tools necessary for addressing many issues that would be escalated to supervisors in other industry settings in customer service. Centene MSRs will be prepared to deal with members with cognitive impairment or limited communication skills, LEP, financial stress, and hard-to-pin-down fears such as lack of trust of "the system." In most cases, non-clinical issues requiring escalation to a Supervisor would relate to new program requirements such as a change in covered services, a new program or process that has not yet been fully implemented, or a member's request to speak with a Supervisor. MSRs will escalate non-clinical questions to the Supervisor of Member Services.

Provider Call Center

A combination of skilled, compassionate, well-trained staff and state-of-the-art communications and data management technology will allow Centene to consistently provide excellent customer service to providers that contact the Provider Services Helpline. Centene's Provider Services Helpline will be managed by a fully-trained team of Provider Services Representatives (PSRs) that possesses experience

in the healthcare industry and an in-depth understanding of the fast-paced dynamic of providers' day-to-day operations. When a provider contacts Centene for questions or information, PSRs will work to ensure that each call is handled thoroughly, timely and efficiently from beginning to end, and that the provider receives the information, education and/or services needed.

Centene's PSRs will be committed to working in partnership with Centene providers. If a provider requests clarification of a process, PSRs are available to educate them on the processes, as applicable. If the provider's concern is outside of the PSRs scope, the PSR will escalate the issue to the assigned Provider Relations Representative or the Claims Liaison (for Claims issues), as applicable. PSRs understand the busy environment in which providers work, and will be committed to assisting them in resolving all matters at hand efficiently.

Our Provider Services Helpline will be staffed by PSRs Monday through Friday, 7:30 a.m. to 6:00 p.m. Central Standard Time. For provider calls received after-hours, and calls received on State-designated holidays, providers may speak with representatives from the 24-hour nurse advice line to coordinate emergency prior authorization requests and discuss urgent or emergent Member issues with a Registered Nurse.

General Inquiry Calls to the Provider Call Center. Centene will make available an Integrated Voice Response solution to all provider callers, affording providers 24/7 access to information such as eligibility, primary physician information, and claim status, including paid date and amount. When providers call, Centene's automatic system will immediately greet and prompt them to select either Spanish or English as their preferred language. After selecting from the language prompt, additional prompts will be available that inquire if the call is a medical emergency or not, and also offers the option to enter a direct extension. The next prompt will verify that they are calling as a provider. Once the provider verification occurs, the prompts inquire to determine the topic of their call, e.g., eligibility, claims, prior authorization request and authorization status, behavioral health, dental services, vision services, if they are a provider interested in joining the network, and lastly "something else." providers selecting the "claims" option are then asked to enter their NPI. Providers may by-pass all options by pressing "0" at any time during the call; this immediately connects them with a PSR ready to assist. In the event of an after-hours call, providers will have the option to leave a voice mail message. If the provider chooses to leave a voicemail, their call is returned by the close of the next business day.

Centene is committed to first call resolution, resulting in optimal customer service and easing the administrative burden placed on Providers.

Call Routing. Centene's PSR team recognizes that call routing extends the time providers spend on the phone with us and, in the interest of provider partners' time, we will strive to keep call routing to a minimum. Call routing will be employed only in those cases when a provider's inquiry involves clinical or administrative issues most appropriately answered by a member of the Medical Management or other functional area staff. If additional information, other than what is immediately available to PSRs, is required in order to resolve a provider's inquiry, PSRs will immediately contact the appropriate department via instant message, call or email to obtain the required information. To further minimize

call transfers, PSR workstations will be equipped with resources such as (CPT/ICD-9/UB-04), CMS-1500 and UB Billing Guidelines, industry-coding manuals, Provider Directories, interdepartmental updates, and workflow documents. Additionally, Centene's call center will be equipped with Count 5's Q Mindshare tool, which provides PSRs with helpful information pushed to their screen. PSRs will also have access to an internal SharePoint page that houses continuously updated resources, such as those listed above, to allow PSRs to consistently and quickly obtain the information needed to address the provider's request.

Claims Inquiry Calls. PSRs handle most claims inquiries from providers, however, when a request involving a complex claims inquiry is received, PSRs advise the provider that the inquiry will require additional research and provide a time estimate within which the provider can expect a response, allowing the PSR to answer other provider calls while the inquiry is researched. PSRs route complex claims inquiries to the local Claims Liaisons via a Contact Relationship Manager system. The Claims Liaison will research and provide a response to the PSR regarding necessary next steps. This arrangement will allow the provider to receive a return call from the same PSR with whom they initially spoke, who is most familiar with the provider's inquiry. This approach holds a single PSR accountable for the entire inquiry, from receipt through research to response, offering a seamless customer service experience for providers.

Call Tracking

Centene's Workforce Analyst will oversee the process for tracking and analyzing call center calls. Centene's Avaya phone system allows the Workforce Analyst or Supervisor to see who is on a call and the length of the call as calls are taking place. This helps them determine if the representative is having any trouble so they may provide live assistance if needed. Avaya can also categorize call duration by half hour increments for call trending and reporting. In addition, Centene's IEX management system allows the Workforce Analyst or Supervisor to monitor what a representative is scheduled to be doing and compares in real time to what the representative is actually doing. This confirms representatives are where they are assigned and helps ensure Centene is sufficiently staffed at all times for the member and provider calls.

For evaluation purposes, Centene uses Uptivity, a quality monitoring platform that records, reviews, and evaluates member and provider calls handled by all Centene affiliated solutions that use the same telephone platform such as NurseWise, Cenpatico, and Nurtur. Uptivity is a scalable solution that will grow and evolve with Centene's evolving business needs.

Call Center Performance Monitoring Tools

Centene uses Uptivity, the quality evaluation software system, to record, review, and evaluate member and provider calls. Uptivity records all audio calls handled by representatives during normal business hours and all after hours calls. Uptivity uses a phonetics-based speech analytics solution to detect key words and phrases as well as silence detection, for both English and Spanish speaking callers. Speech analytics identifies call scenarios and agents who may need coaching to more closely follow best

practices. Centene staff will use Uptivity to train and coach representatives to improve caller satisfaction, empowerment, and morale.

Centene uses Count 5's Q Mindshare change management tool to assist the call center in getting reliable information to selected representatives at appropriate times by pushing relevant information directly to representatives' desktops. Content can be scheduled to be released in advance or immediately. After content is released, representatives receive a notification indicating that new information needs to be reviewed. Content can be created within the application or accessed externally, such as from Centene's Cornerstone Learning management system.

Reporting is a key feature of the Q Mindshare application. Supervisors are able to view participation rates, see their scores on assessments, and use feedback as an opportunity to engage with representative participants. Representatives have the ability to provide feedback in the form of both ratings and comments. In addition, representatives are able to access the information at a later time for reinforcement, if needed.

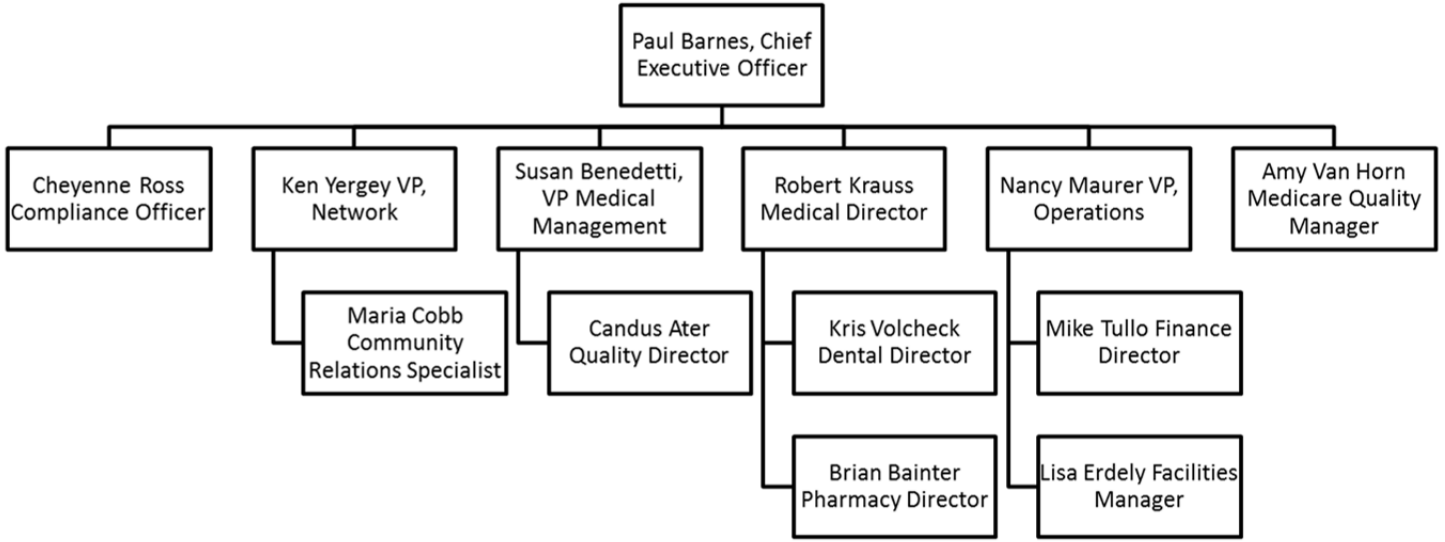
ATTACHMENT G

HEALTH NET ACCESS KEY STAFF LISTING

KEY STAFF	NAME	PHONE NUMBER	CELL PHONE	WORK EMAIL
Administrator/CEO	Paul Barnes	480-567-9011	480-406-8264	PABARNES@CENTENE.COM
Medical Director/CMO	Mary Ann Lecavalier	602-764-1689		MARYANN.X.LECAVALIER@HEALTHNET.COM
Chief Financial Officer	Trista Loops	602-794-1481		TRISTA.A.LOOPS@HEALTHNET.COM
Pharmacy Coordinator	Pam White	520-258-7394		PAMELA.J.WHITE@HEALTHNET.COM
Dental Director	Hector Gonzales	602-686-0253		HECTOR.V.GONZALEZ@HEALTHNET.COM
Compliance Officer	Susan Gilkey	520-258-5705		SUSAN.A.GILKEY@HEALTHNET.COM
Grievance Manager	Mary Lyngby	602-794-1678		MARY.B.LYNGBY@HEALTHNET.COM
Business Continuity Planning Coordinator	Chandra Hara	602-794-1852		CHANDRA.L.HARA@HEALTHNET.COM
Contract Compliance Officer	Chandra Hara	602-794-1852		CHANDRA.L.HARA@HEALTHNET.COM
Quality Management Coordinator	Helen Lansche	602-794-1661		HELEN.C.LANSCHE@HEALTHNET.COM
Performance/Quality Improvement Coordinator	Norma Barkley	602-794-1782		NORMA.X.BARKLEY@HEALTHNET.COM
Maternal Health/EPSDT (child health) Coordinator	Cheryl Walton	602-794-1539		CHERYL.L.WALTON@HEALTHNET.COM
Medical Management Coordinator	Rhonda Combs	602-794-1712		RHONDA.L.COMBS@HEALTHNET.COM
Behavioral Health Coordinator	Karen Mavrikos	602-794-1493		KAREN.X.MAVRIKOS@HEALTHNET.COM
Member Services Manager (Interim)	Valerie Noor	602-794-1503		VALERIE.A.NOOR@HEALTHNET.COM
Provider Services Manager	Filiberto Gurrola	602-794-1486		FILIBERTO.L.GURROLA@HEALTHNET.COM
Claims Administrator	Lavaun Skallerup	602-794-1851		LAVAUN.G.SKALLERUP@HEALTHNET.COM
Provider Claims Educator	Mary Niles	602-794-1407		MARY.L.NILES@HEALTHNET.COM
IS Administrator	Mike Flynn	602-794-1497		MICHAEL.J.FLYNN@HEALTHNET.COM

ATTACHMENT H

BRIDGEWAY ORGANIZATIONAL CHART (at closing)



ATTACHMENT Ia

PRO-FORMA FINANCIAL STATEMENTS

Health Net Access, Inc.

Balance Sheets (in 000s)

	FORECAST AS OF DECEMBER 31,		
	2016	2017	2018
ASSETS			
Cash & investments	127,360	116,832	130,180
Capitation / supplemental / risk adj receivable	719	812	914
Reconciliation receivable[1]	373	-	-
Reinsurance receivable	4,110	4,641	5,231
Deferred income taxes	482	482	482
Due from parent & affiliates	51	58	65
Health care receivables	535	572	613
Other assets	925	1,044	1,177
Total assets	134,554	124,441	138,663
LIABILITIES AND STOCKHOLDERS' EQUITY			
Claims liabilities	76,875	85,718	96,647
Premium deficiency reserve	-	-	-
Reconciliation payable[2]	26,071	6,966	7,114
Federal income taxes	65	192	223
Due to parent & affiliates	4,624	5,221	5,886
Other liabilities	1,233	1,392	1,569
Total liabilities	108,868	99,489	111,440
Stockholders' equity	25,686	24,952	27,224
Total liabilities and stockholders' equity	134,554	124,441	138,663

PROJECTION ASSUMPTIONS

1 Reconciliation receivables relate to adult Medicaid expansion reconciliation
2 Reconciliaton payables relate to prospective and PPC reconciliations

ATTACHMENT Ib

PRO-FORMA FINANCIAL STATEMENTS

Health Net Access, Inc.

Statutory-Basis Statements of Operations (in 000s)

	FORECAST FOR YEAR ENDING DECEMBER 31,		
	2016	2017	2018
Period end membership	76	84	92
Member months[1]	907	998	1,098
REVENUES			
Premiums[2]	286,840	323,413	364,648
Health insurer fee	7,742	9,231	10,311
Total premiums	294,582	332,644	374,959
Investment income	1	1	1
Total revenue	294,583	332,645	374,960
EXPENSES			
Total benefits[2]	259,343	289,176	326,046
Premium deficiency reserve	(2,790)	-	-
Health insurer fee	5,034	6,002	6,704
Premium tax	5,892	6,653	7,499
Selling, general & administrative expenses[3]	27,104	30,250	33,759
Total expenses	294,583	332,081	374,008
Net gain from operations	-	564	952
Income tax[4]	1,762	2,298	2,679
NET INCOME	(1,762)	(1,734)	(1,728)
G&A ratio	9.9%	9.8%	9.7%

PROJECTION ASSUMPTIONS

1 Pro-forma assumes auto assignment enrollment will be reinstated in 2016 and approximately 10% membership growth in 2017 and 2018

2 Gross margin assumes continuation of historical annual premium changes, consistent member mix and improvement in medical loss ratio through medical management initiatives.

3 Selling, general and administrative expense are reduced below the AHCCCS mandated administrative cost maximum of 10% starting in 2016

4 Income taxes projections at a 35% tax rate. Projection includes impact of non-deductibility of the Health Insurer Fee

Health Net Access, Inc.

Statutory-Basis Statements of Changes in Stockholders' Equity

	FORECAST FOR YEAR ENDING DECEMBER 31,		
	2016	2017	2018
Beginning balance	27,448	25,686	24,952
Net income or loss	(1,762)	(1,734)	(1,728)
Capital contributions	-	1,000	4,000
Ending balance	25,686	24,952	27,224
AHCCCS Capital requirement ($170 per member):	12,852	14,256	15,682

ATTACHMENT Ic

PRO-FORMA FINANCIAL STATEMENTS

Health Net Access, Inc.

Statutory-Basis Statements of Cash Flows (in 000s)

	FORECAST FOR YEAR ENDING DECEMBER 31,		
	2016	2017	2018
CASH FROM OPERATIONS			
Net loss	(1,762)	(1,734)	(1,728)
Adjustments to reconcile net loss to net cash provided (used) in operations:			
Provision for deferred federal income taxes	976		
Change in assets and liabilities:			
Capitation / supplemental / risk adj receivable	(19)	(93)	(103)
Reinsurance receivable	(110)	(531)	(590)
Reconciliation receivable and payable	616	(18,732)	148
Provider receivables and pharmaceutical rebates	(35)	(37)	(40)
Income taxes receivable from affiliate	230	126	32
Prepaid and other assets	(25)	(119)	(133)
Current due from or to affiliates	122	591	657
Medical claims payable	13,875	8,843	10,929
Premium deficiency reserve	(2,790)	-	-
Change in other liabilities	33	159	177
Net cash from operations	11,112	(11,528)	9,348
CASH FROM INVESTMENTS			
Net cash from other investments	-	-	-
CASH FROM FINANCING			
Capital contribution	-	1,000	4,000
Stockholder dividends paid	-	-	-
Net cash from financing activities	-	1,000	4,000
CASH & SHORT-TERM INVESTMENTS			
Change in	11,112	(10,528)	13,348
Beginning of year	116,248	127,360	116,832
End of year	127,360	116,832	130,180

Note: Cash flows projections include assumptions necessary to meet contractual AHCCCS claims payment requirements.

ATTACHMENT J

MEMBER CONNECTIONS PROGRAM

Centene's intensive, grassroots outreach programs, is called MemberConnections. MemberConnections Representatives (MCRs) are hired from within the communities we serve to establish community partnerships to meet the needs of members, and/or support the overall wellness and quality of local communities. For instance, the MCRs may attend community health and wellness events, local community celebrations (e.g., American with Disabilities Act birthday celebrations), peer training events (e.g., money management and advocating for your health care needs), education events (e.g., safe transfers and avoided falls), and caregiver events (e.g., caregiver appreciation events and stress reduction strategies). MCRs receive intensive training through the MemberConnections Program to ensure that the member outreach and education practices are culturally competent and accessible to members.

MemberConnections Representatives (MCRs) can offer general health education and literacy, as well as teach members about the specific Care for Kids services available to them and how/when to access them. MCRs also play an important role helping members address and overcome barriers to access, such as not having a PCP, transportation and child care issues.

School-based Events. Through Centene's Adopt-a-School initiative, Member Connections Representatives (MCRs) partner with public elementary schools across the state monthly to read books about health and wellness to students in preschool and up to Grade 5, and also complete an activity related to the book topic. For example, we read Scholastic's "Froggy Goes to the Doctor" book that addresses the anxiety some children have about doctor visits, and focuses on the importance of regular visits. MCRs ask questions about the stories, and the student who correctly answers the most questions receives a copy of the Scholastic Book. We often read from the Boingg and Sprockette series, particularly Adventures in Fitropolis, or we talk about good nutrition and provide healthy snacks and the Super Centeam 5 Cookbook. Students complete activities related to the focus topic, such as coloring pages from the Scholastic series and fitness games, and they receive related items such as coloring books and colors, cookbooks, and water bottles.

Figure: Adopt-a-School reading event

ATTACHMENT K

SMART START PROGRAM

Start Smart for Your Baby™

Centene's award winning Start Smart for Your Baby™ (Start Smart) Program incorporates health and wellness promotion, care coordination, disease management and case management services to decrease preterm delivery and improve the health of moms and their babies. This multi-faceted approach to improve prenatal and postpartum care includes enhanced member outreach and incentives, wellness materials, intensive one-on-one case management, and supports the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease.

An essential component of the Start Smart program is the Notification of Pregnancy (NOP) process. The NOP process is a well-organized approach that aims to identify pregnant members at risk for pregnancy complications early in pregnancy and establish relationships between the member, provider, and health plan staff. Based on information obtained in the NOP, we are able to stratify and assign a risk score that determines the most appropriate level of maternal management. We may also identify pregnant women by mining pharmacy data for prenatal vitamins or other indications of pregnancy, reviewing lab data for pregnancy tests and looking at visits and coding of office visits from OB/GYN Providers.

The Start Smart program provides all pregnant members with tools to empower them to be active participants in their healthcare team, including wellness programs, educational information and access to Care Management. Receipt of the NOP triggers the mailing of the Prenatal Care Packet. Members may also access pregnancy and postpartum health information on the plan website including relevant podcasts. Notification of the infant's birth triggers the Newborn Care Packet which includes information for the mother about the postpartum period as well as caring for her newborn.

Pregnant members identified as moderate or high risk via the NOP are assigned a Case Manager with obstetrical nursing experience. The Case Manager monitors pregnant members for compliance to scheduled appointments and provides ongoing telephonic education and support such as managing nausea and signs of preterm labor. Subparts of the Program include identification for and education about 17 hydroxy-progesterone, Text4Baby, breastfeeding support and specialized support for families of infants admitted to the NICU. Our OB Care Team is supported by a Centene Obstetrician who conducts weekly telephone rounds with the OB Case Managers to advise the team on overcoming obstacles and recommending interventions for complex cases.

The diagrams below show the breadth of the Start Smart program and its support of members, providers and employees.

Figure 1: Start Smart for Your Baby – Member Supports

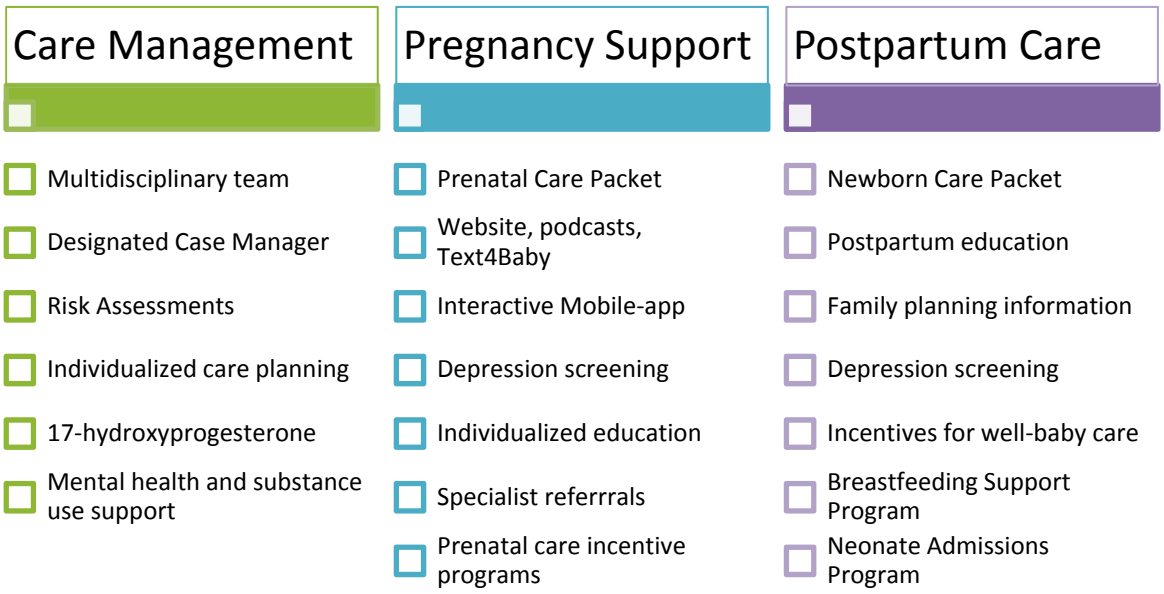
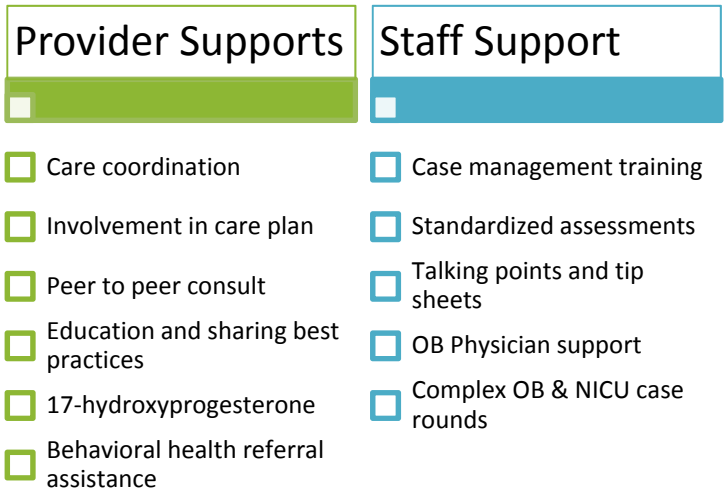


Figure 2: Start Smart for Your Baby Provider & Staff Supports



The Start Smart program, implemented in 2008, aims to increase the availability and quality of obstetrical and pediatric care services to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, low birth weights and infant disease. Centene Corporation manages over 100,000 Medicaid deliveries per year in multiple states and uses Start Smart to identify and stratify pregnant women through the use of NOP assessments and provides members with individualized care plans, education, incentives, support and other tools. Early identification of pregnant women and their risk factors through the NOP process and the monitoring of claims data is a

crucial element in improving delivery and birth outcomes. With the help of the program, we have seen improvements in key indicators of birth outcomes, including statistically significant decreases in NICU admission rates and NICU days/1,000 births, and decreases in all three measures of low birth weight. The percent of low (1500 to 2499 grams) birth weight deliveries has decreased from 9.23% at baseline to 8.32% in 2014 ($p < .01$), while the percent of very low birth (250 to 1499 grams) weight deliveries has decreased from 1.75% at baseline to 1.51% in 2014 ($p < .01$). These reductions have resulted in substantial savings. Given the volume of deliveries covered, we estimate that the program ***reduced neonatal costs by over $20 million*** in 2014 alone.

ATTACHMENT L

IMPLEMENTATION OF CENTENE CLINICAL PROGRAMS

CENTENE CLINICAL PROGRAM	**Projected Implementation (quarter after closing)**
MemberConnections® Program	**2nd**
Sickle Cell Management Program	**2nd**
Psychotropic Medication Utilization Review (PMUR)	**3rd**
Start Smart for Your Baby™ Program	**4th**
Substance Use in Pregnancy Program	**4th**

ATTACHMENT M

NOTIFICATION TO PROVIDERS

Possible Ownership Change for Health Net

Health Net and Centene are in process of an ownership change whereby Centene would acquire Health Net, including the Health Net Access plan. Health Net and Centene are committed to quality health care and view this potential change as an opportunity to pursue higher levels of quality and access to health care services for our members and excellent customer support for our providers.

How Does this Affect Health Net Access Providers?

Health Net Access does not anticipate changes to current provider contractual arrangements. Providers would continue to receive quality customer service from our current provider services staff.

How Can a Provider Get More Information?

As discussion continues Health Net Access providers can keep informed through our web site or by contacting Provider Service.

visit the website at www.healthnetaccess.com

Health Net Access Provider Services: 1-888-788-4408 open 24 hours a day, 7 days a week.

ATTACHMENT N

MEMBER NOTIFICATION

Possible Ownership Change for Health Net

Health Net and Centene are in process of an ownership change whereby Centene would acquire Health Net, including the Health Net Access plan. Health Net and Centene are committed to quality health care. Centene and Health Net see the possible change as a chance to give better quality care to our members and excellent support to our providers.

How Does this Impact Me If I am a Member of Health Net Access?

As a Heath Net Access member, you would not be impacted by the change in ownership. You will still be able to see the same network providers. You will receive the same Medicaid covered services.

How Can I Get More Information?

As talks continue, Health Net Access members can get up to date information on our web site and by calling the Member Services center.

visit the website at www.healthnetaccess.com

Health Net Access Member Service: 1-888-788-4408

Open 24 hours a day, 7 days a week