HEALTH NET, INC.

GROWTH

2000 Annual Report

HEALTH NET, INC. 2000 Annual Report

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Health Net's mission is to ensure that our members have access to quality and affordable health care and to contribute to improvements in the overall health care system by:

- Winning the ongoing trust of the public, our members, our customers, our provider partners and our associates by developing lasting, affirmative relationships
- Leading the markets we serve by offering consumer-responsive products
- Adding value by arranging health care services that combine quality, efficiency and affordability
- Implementing a leading-edge infrastructure that enables state-of-the art service
- Maintaining a fulfilling work environment that allows associates to maximize their potential
- Employing capital efficiently to provide consistently competitive returns to our stockholders

Health Net®

Financial Highlights

Health Net, Inc.

(Amounts in thousands, except per share data)	Year ended December 31, 2000	1999[3]	1998[3]	1997[3]	1996[3]
STATEMENT OF OPERATIONS DATA[2]:					
REVENUES					
Health plan services premiums	$7,351,098	$7,031,055	$7,124,161	$5,482,893	$5,395,125
Government contracts/Specialty services	1,623,158	1,529,855	1,411,267	1,408,402	1,225,723
Investment and other income	102,299	86,977	93,441	114,300	88,392
Total revenues	9,076,555	8,647,887	8,628,869	7,005,595	6,709,240
EXPENSES					
Health plan services	6,242,282	5,950,002	6,090,472	4,470,816	4,606,574
Government contracts/Specialty services	1,080,407	1,002,893	924,075	990,576	995,820
Selling, general and administrative	1,296,881	1,301,743	1,413,771	1,185,018	868,196
Depreciation and amortization	105,899	112,041	128,093	98,353	112,916
Interest	87,930	83,808	92,159	63,555	45,372
Asset impairment, merger, restructuring and other costs	–	11,724	240,053	286,525	27,408
Net loss (gain) on sale of businesses and properties	409	(58,332)	(5,600)	–	–
Total expenses	8,813,808	8,403,879	8,883,023	7,094,843	6,656,286
Income (loss) from continuing operations before income taxes	262,747	244,008	(254,154)	(89,248)	52,954
Income tax provision (benefit)	99,124	96,226	(88,996)	(21,418)	14,124
Income (loss) from continuing operations	163,623	147,782	(165,158)	(67,830)	38,830
Discontinued operations[2]:					
Income (loss) from discontinued operations, net of tax	–	–	–	(30,409)	25,084
Gain (loss) on disposition, net of tax	–	–	–	(88,845)	20,317
Income (loss) before cumulative effect of change in accounting principle	163,623	147,782	(165,158)	(187,084)	84,231
Cumulative effect of a change in accounting principle, net of tax	–	(5,417)	–	–	–
Net income (loss)	$ 163,623	$ 142,365	$ (165,158)	$ (187,084)	$ 84,231
BASIC EARNINGS (LOSS) PER SHARE:					
Continuing operations	$ 1.34	$ 1.21	$ (1.35)	$ (0.55)	0.31
Income (loss) from discontinued operations, net of tax	–	–	–	(0.25)	0.20
Gain (loss) on disposition, net of tax	–	–	–	(0.72)	0.16
Cumulative effect of a change in accounting principle	–	(0.05)	–	–	–
Net	$ 1.34	$ 1.16	$ (1.35)	$ (1.52)	$ 0.67
DILUTED EARNINGS (LOSS) PER SHARE:					
Continuing operations	$ 1.33	$ 1.21	$ (1.35)	$ (0.55)	$ 0.31
Income (loss) from discontinued operations, net of tax	–	–	–	(0.25)	0.20
Gain (loss) on disposition, net of tax	–	–	–	(0.72)	0.16
Cumulative effect of a change in accounting principle	–	(0.05)	–	–	–
Net	$ 1.33	$ 1.16	$ (1.35)	$ (1.52)	$ 0.67
Weighted average shares outstanding:					
Basic	122,471	122,289	121,974	123,333	124,453
Diluted	123,453	122,343	121,974	123,333	124,966
BALANCE SHEET DATA:					
Cash and cash equivalents and investments available for sale	$1,533,637	$1,467,142	$1,288,947	$1,112,361	$1,122,916
Total assets	3,670,116	3,696,481	3,863,269	4,076,350	3,423,776
Notes payable and capital leases – noncurrent	766,450	1,039,352	1,254,278	1,308,979	791,618
Stockholders' equity [1]	1,061,131	891,199	744,042	895,974	1,183,411
OPERATING CASH FLOW	$ 366,163	$ 297,128	$ 100,867	$ (125,872)	$ (6,666)

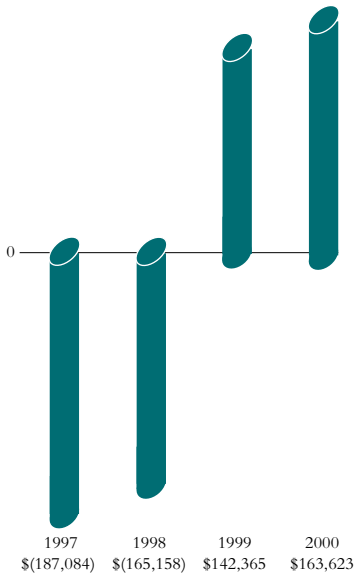
(1) No cash dividends were declared in each of the years presented.

(2) See Note 3 to the Consolidated Financial Statements for discussion of dispositions during 1999 impacting the comparability of information. The Company purchased four health plans and one insurance company during 1997 which also impacts the comparability of information. Additionally, the Company's workers' compensation segment sold in 1998 and physician practice management segment sold in 1996 have been accounted for as discontinued operations.

(3) Certain reclassifications have been made to 1999, 1998 and 1997 statements of operations data to conform to the 2000 presentation. Comparable information for 1996 reclassifications is not available.

Net Income (Loss)

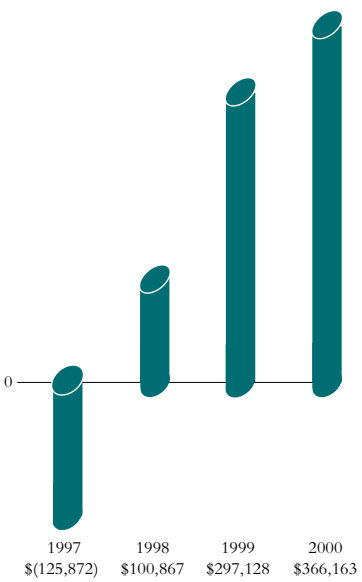
(in thousands)



Selling, General and Administrative (including depreciation) Ratio

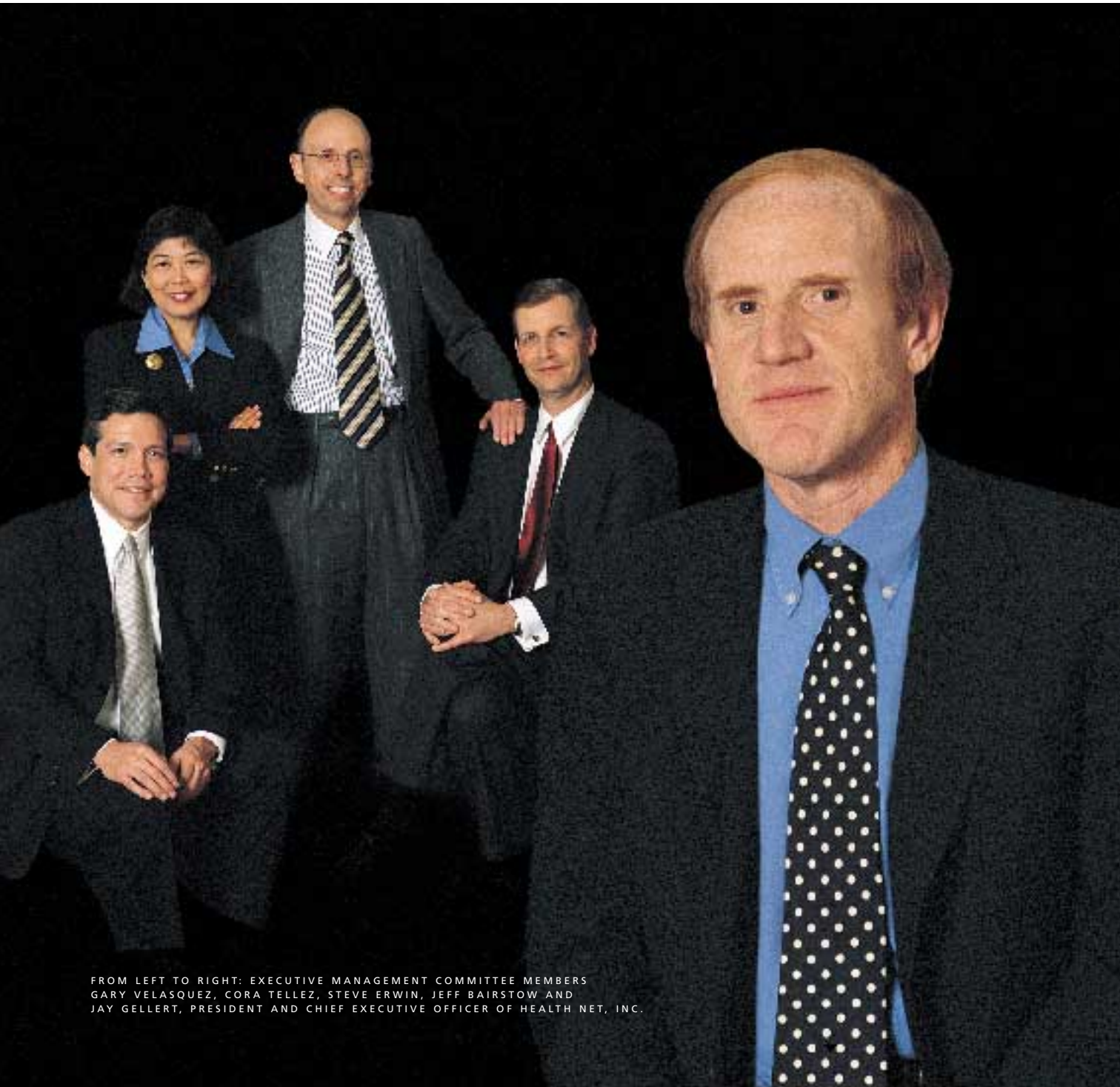
Operating Cash Flow

(in thousands)



Debt-to-Total Capital Ratio

GROWTH



FROM LEFT TO RIGHT: EXECUTIVE MANAGEMENT COMMITTEE MEMBERS
GARY VELASQUEZ, CORA TELLEZ, STEVE ERWIN, JEFF BAIRSTOW AND
JAY GELLERT, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF HEALTH NET, INC.

To Health Net Stockholders -

I am very pleased to report to you on a very successful 2000 for Health Net, Inc. Last year this letter discussed our hopes for a major turnaround. In 2000, we fulfilled many of our hopes as we virtually completed the turnaround and began to grow again. To signal this new beginning, on November 3, 2000, we changed the company name to Health Net, Inc. from Foundation Health Systems, Inc.

Long the name of our California health plan, Health Net is a name that evokes our future – a future when all of our health plans and most of our other operations will be known as Health Net. The health plans will strive to generate consistent enrollment growth based on outstanding service and consumer-responsive product designs. We hope to deliver value-added medical programs and increased operating efficiencies based on new technologies. If we do these things and help improve the health of our members, we believe all the measures of our financial performance will grow as well.

Growth is vital to any successful enterprise and it is essential to our future. In 2000, we made an excellent start on our new growth path as all of our key financial measurements improved. For the year, revenue increased by 5 percent to $9,076,555,000, as we added approximately 190,000 new members in continuing health plans with increased premiums that rightly reflected underlying health care cost trends. This growth does not count members in plans we sold either in 1999 or early in 2000.

Net income climbed by 15 percent to $163,623,000 or $1.33 per diluted share. In 2000, our margins expanded. For example, our margin on earnings before interest, taxes, depreciation and amortization rose to 5 percent, from 4.5 percent in 1999. Our selling, general and administrative (SG&A) expense ratio declined to 15.2 percent from 16.0 percent in 1999. Our efficiency improvement efforts, along with our investments in new technology, helped drive this ratio lower. There is more room for improvement in this ratio in the future as we continue to create new, more efficient business processes and more direct, less cumbersome interactions with our provider partners.

Operating cash flow improved by more than 23 percent, to $366,163,000 in 2000 from $297,128,000 in 1999 and from just over $100 million in 1998. This substantial improvement helped us reduce debt to $766,450,000 at year-end. This reduction in debt, along with an increase in stockholders' equity to $1.1 billion, helped lower the debt-to-capital ratio to 42 percent at the end of the year.

As you read this, the debt-to-capital ratio is even lower thanks to a landmark settlement between Health Net and the Department of Defense (DoD) finalized just after year-end. On January 3, 2001, we announced a $389 million settlement with the DoD, thereby dramatically reducing the amounts receivable under government contracts and allowing us to pare debt even further. These new numbers will be reflected in the first quarter of 2001. Shortly after this announcement, Standard & Poor's upgraded Health Net's debt rating to investment grade, another important event signaling the impending completion of the turnaround.

The amounts receivable under government contracts on the balance sheet relates to our three TRICARE contracts with the DoD. Under these contracts, we serve the health care needs of approximately 1.5 million military retirees and dependents of active duty military personnel. At the end of 2000, the amounts receivable under government contracts stood at $334,187,000.

One measure of our financial performance that did not improve in 2000 was the health plan medical care ratio (MCR), which measures health care costs against premiums. The issue of medical cost inflation could easily consume this entire annual report. There are demographic, technological, financial and myriad other reasons why health care costs are rising. Our responses to this challenge are many, but first among them is the necessity to price our services consistent with these cost trends. We must also maintain reserves for health care costs. In 2000, our reserves for claims payable and our days claims payable, a standard industry measure of reserve adequacy, both improved.

The issue of health care costs extends to the financial health of our provider partners that we view as a vital responsibility. We try to ensure that our providers are compensated fairly and efficiently, so that these providers of care can meet the needs of our members – and employer groups and the government know their premium dollars are being spent prudently.

The MCR in 2000 was as expected, and we believe it will decline by no more than a few tenths of a percent in the near future.

The fastest growing component of health care costs is pharmaceuticals. Health Net experienced an approximately 9 percent increase in pharmacy costs in 2000. To address this trend, in 2000 we expanded our pharmaceutical programs with a wider variety of co-payment structures. These provide greater choices to our members, while continuing to keep this very popular benefit affordable.

We continue to work on significant improvements in SG&A. As I noted, SG&A dropped in 2000. During the year there were many exciting developments, both in SG&A initiatives and in our New Ventures Group.

The New Ventures Group was established in late 1999 to develop new processes utilizing technological enhancements such as the Internet. For example, in the Northeast we have signed up more than 3,500 physicians to our connectivity project that uses the Internet to speed administrative functions and reduce administrative burdens for doctors' offices.

The Group developed and introduced in California, Questium (www.Questium.com), a consumer Web site that allows members to be more actively involved in the design and management of their health benefits. It's proving to be very popular with our members and we'll be rolling it out to our other health plans and to our TRICARE members throughout 2001.

Our success in 2000 was also based on exemplary performance by our Government and Specialty Division. We are very pleased with our position in the TRICARE program. In 2000, we secured two-year contract extensions for Region 11 in the Pacific Northwest and for Region 6, which covers Texas and three other states. We hope to receive a two-year extension on the third contract for Regions 9, 10 and 12 that covers California, Hawaii and two other states.

We continue to see a bright future for our behavioral health subsidiary, MHN. It added new members in 2000 and continued its leadership in Employee Assistance Programs (EAPs).

Overall, our health plans had a very successful 2000. In early 2001, however, we announced a definitive agreement to sell our Florida plan. Unfortunately, we reached the conclusion that this plan was too small to succeed in the highly competitive south Florida market.

For our other health plans, it is clear that our focused and innovative marketing efforts, our emphasis on customer service and our attractive product designs are drawing new members, especially in our key New York and California markets. As a measurement of our success, our plans in California and the Northeast were rated #1 in member satisfaction surveys conducted by a major national firm.

We have also done an outstanding job in various state Medicaid programs. In California, our Medi-Cal program and our involvement in newer, state-sponsored programs for children and families generated enrollment growth in 2000.

As we enter a period of economic uncertainty, we believe employers will show more interest in managed care products as they strive to maintain attractive health benefit packages. In such a climate we believe success will come to plans with strong market positions and the ability to offer flexible benefit packages. In fact, our turnaround prepared us well for virtually any economic scenario. We are now concentrated in large dynamic markets, with competitive advantages and expertise in a range of health insurance products.

Getting to the point where we could focus on growth was the goal of our turnaround. While we are pleased with this achievement, we still have the challenges of consistent, profitable growth coupled with improved technology-based operating efficiencies ahead of us – challenges we are all confident we can meet – just as we met the challenges of the turnaround.

None of what has happened in the last two years could have been possible without a dedicated team of associates who have worked long and hard against some pretty tough odds. They are led by our Executive Management Committee (EMC), pictured with this letter. The EMC is a cohesive team working with an admirable focus to our shared goals. They and all of our associates are to be congratulated for the successful completion of the turnaround and the resumption of growth.

FROM LEFT TO RIGHT: EXECUTIVE MANAGEMENT COMMITTEE MEMBERS
DAVID OLSON, KARIN MAYHEW, CURT WESTEN

On a very sad note, however, the Health Net family misses Karen Coughlin and Mary Gilligan. Karen, who led a remarkable turnaround in the Northeast, passed away just after Thanksgiving. Mary, who had just begun to make an impact on our Arizona plan, passed away just after the first of the year. Their contributions live on in the performance of this company and in the hearts and minds of all the people, inside and outside Health Net, they touched. We honor their memories and dedicate ourselves to continuing on the paths they began. They were both true credits to the best of what this industry offers.

We thank you, the stockholders of Health Net, for your patience and support. We hope that our success in 2000 is a harbinger of continued success in the years ahead.

Sincerely,

JAY M. GELLERT
PRESIDENT AND CHIEF EXECUTIVE OFFICER
MARCH 12, 2001

RELIABLE

LINDA STRECKFUSS, FORMER MEMBER,
PHS HEALTH PLANS

Linda Streckfuss attributes her good health to PHS Health Plans and a prevention program it introduced several years ago on the importance of regular mammograms. ❦ Linda, who had no family history of breast cancer, never took the time to have a mammogram. After receiving several reminder postcards from PHS Health Plans, she finally scheduled a mammogram shortly after her 50th birthday. Two X-rays of her left breast and 15 X-rays of her right breast prompted a biopsy, which tested positive for cancer. On February 8, 1999, Linda had her right breast removed. A subsequent biopsy of her lymph nodes indicated the cancer was contained. ❦ Today, at age 52, Linda is cancer free. She lives with her husband and four children by the shore in Leonardo, New Jersey.

By Your Side - With more than five million members throughout the country, Health Net provides a variety of health care services to a wide range of individuals. From children and seniors to military retirees and low-income individuals, Health Net is working to create products and programs to fit the varying health care needs of its customers.

In 2000, Health Net of California introduced an array of new health care products, offering consumers different pricing options and benefit structures for a variety of lifestyles. It also launched "Salud con Health Net," a cross-border initiative that offers products designed to provide affordable health care for Latinos and their families in both California and Mexico.

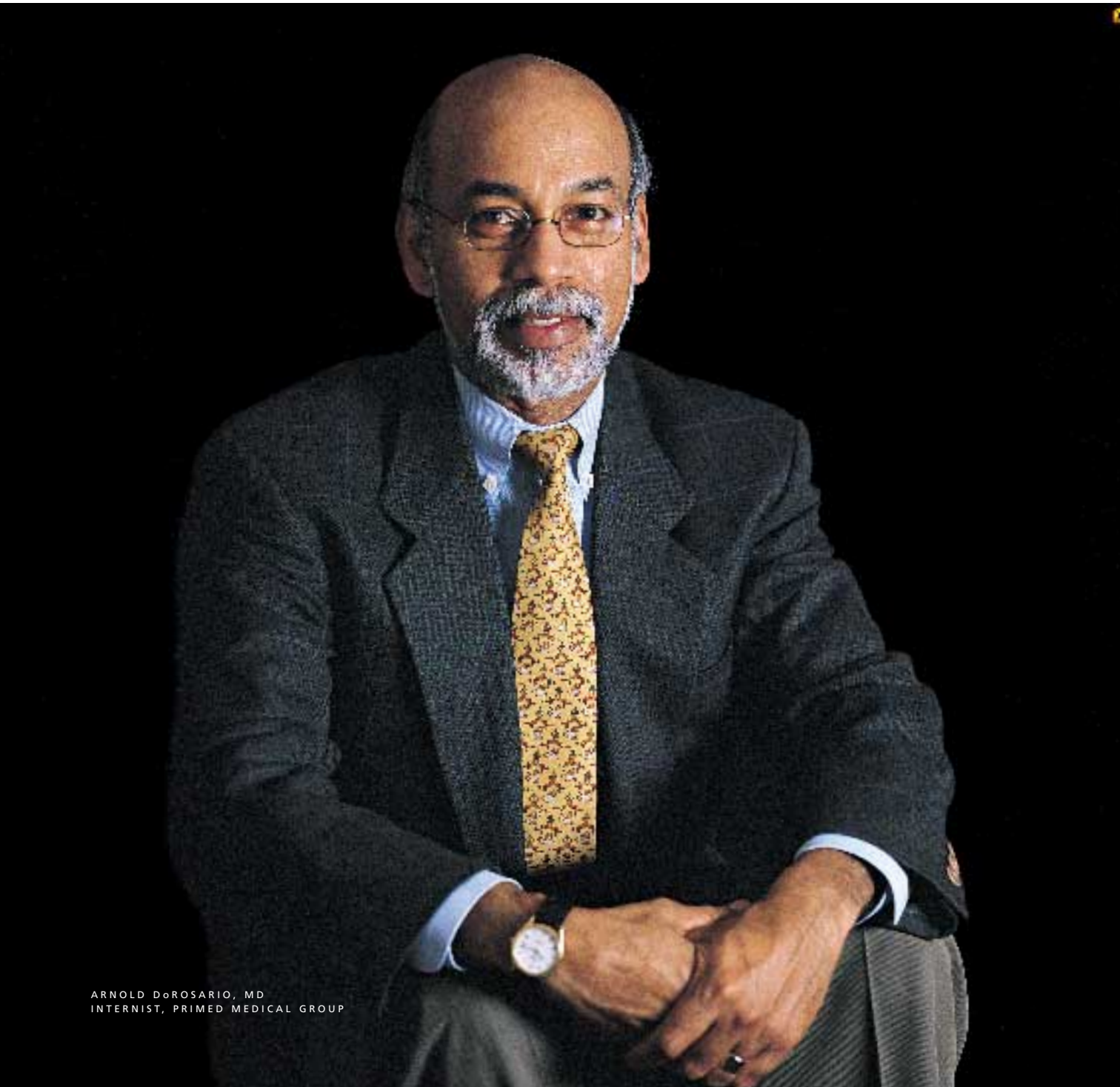
To promote prevention and wellness, Health Net health plans also conduct member education campaigns, reminding women when it is time for a mammogram and educating men on the importance of prostate cancer screening. In California, Health Net was the first health plan to launch a Web site for teenagers devoted solely to important teen health issues such as depression, eating disorders and substance abuse.

PHS Health Plans experienced solid results with its End-Stage Renal Disease Program. The national mortality rate for Americans who suffer from this condition is just over one percent, but for patients participating in the PHS program between April 1999 and March 2000, the mortality rate was one-third lower than the national average.

The company's behavioral health care subsidiary, MHN, collaborates with employer groups to develop workplace programs designed to improve health care services and reduce employee absenteeism. Working closely with one employer in particular, MHN's Psychiatric Disability Management Program significantly reduced the amount of time employees spent on disability leave by ensuring employees had access to practitioners and quality health care services, and educating providers on workplace issues.

Young or old, sick or well, Health Net subsidiaries are developing products to provide affordable health care coverage and population-based programs to keep its members well and improve the quality of life for those individuals with chronic conditions.

COLLABORATIVE



ARNOLD DoROSARIO, MD
INTERNIST, PRIMED MEDICAL GROUP

The administrative hassle of working with a health plan was taking away the pleasure of practicing medicine. He was spending too much time on the phone dealing with administrative issues - time he could be spending with patients. Something had to change. ❦ In August of 1999, Dr. DoRosario called PHS Health Plans to voice his frustration. PHS suggested they work together to develop a solution to the issues affecting his practice. ❦ In February of 2000, PHS and PriMed launched an Internet-based program to replace paper-based administrative tasks and phone calls. Today, the medical group checks eligibility and submits claims, authorizations and referrals over a secure Web site, allowing for real-time transactions - and almost cutting in half the time doctors and their staffs previously spent on these tasks.

Working Together -

Through its partnerships with health care providers, technology companies and other health plans, Health Net is working to improve and simplify processes for all of its stakeholders. In 2000, the company and its subsidiaries introduced several initiatives designed to improve relationships with consumers and physicians.

CAQH

In early 2000, Health Net joined the Coalition for Affordable Quality Healthcare (CAQH) - a coalition representing 24 of the nation's largest health plans. CAQH is committed to working with others in the medical community to address issues where collective action will make life simpler and easier for consumers and their doctors. Through several initiatives, CAQH is developing programs to improve access to quality health care coverage; work with doctors to improve health care quality; and make administration and information easier for doctors and consumers. Jay Gellert, chair of CAQH's Administrative Simplification Committee, has committed Health Net to work closely with CAQH to achieve these goals.

NAVINET

In February, PHS Health Plans launched an Internet-based pilot project called NaviNet with the Connecticut-based medical group PriMed to reduce the administrative burden experienced by physicians and medical staff.

Developed and owned by NaviMedix, Inc., NaviNet enables medical offices to expediently handle eligibility inquiries, referrals, authorizations, claims and other administrative tasks via the Internet.

The results from this program are impressive: Medical offices are experiencing a 50 to 75 percent reduction in the time spent resolving claims, processing referrals and verifying membership eligibility. Due to its success, PHS had rolled out NaviNet to more than 3,500 Connecticut physicians by year-end.

MEDUNITE

In addition to the NaviNet project, Health Net led the effort for the industry-sponsored provider connectivity initiative called MedUnite.

During the early days of MedUnite, Health Net brought together health plans and some of the nation's most innovative and successful technology companies to develop an Internet-based connectivity solution to reduce transaction costs and provide physicians with a standard, easy-to-use method for transacting business with health plans.

CANDID

REBECCA BAUGHMAN, RN, BS, CCM
HEALTH NET OF CALIFORNIA ASSOCIATE

It's no secret. From time to time, some doctors decide to stop working with managed health care plans. Regardless of why a doctor leaves the network, Health Net does everything it can to ensure continuity of care for its members. That's where Rebecca Baughman comes in. A registered nurse for 40 years and a case manager for 10 years, Becky is one of many nurses who works in Health Net of California's Transition of Care Unit. Her job: To ensure that members undergoing an "active course of treatment" continue to be treated by their physician, regardless of the physician's contractual relationship with the health plan. "The doctor-patient relationship is important, and we do all we can to ensure continuity of care for our members," says Becky.

Fostering A Dialogue -

Together, Health Net subsidiaries employ thousands of doctors, nurses, care managers and customer service representatives. On a daily basis, these individuals interact with members, beneficiaries, physicians and other health care practitioners from all over the country to ensure that more than five million members get the services they need, when they need them.

There are times, however, when members dispute a coverage decision made by either the member's medical group or the health plan. When this happens, consumers want to know that there are safeguards in place to ensure a fast and fair resolution. That's why all Health Net health plans use a third-party, independent review process. This process, which allows for independent oversight by specialty-matched physicians not affiliated with the health plan, gives consumers confidence in the system and ensures a quick resolution for both the member and the health plan.

Health Net of California led the charge for third-party, independent review as the first California health plan to voluntarily adopt the program in May of 1998. Today, non-emergent disputes in California are resolved within 30 days, with urgent cases resolved in less than 72 hours. In January of 2000, third-party, independent review became law in California, as it now is in most states.

Health Net subsidiaries have made significant progress over the last several years, yet more is being done to foster better relationships with physicians, hospitals and members. For example, in late 2000 Health Net health plans launched an initiative to decrease the inappropriate prescribing of antibiotics in an effort to control the emergence of drug resistant bacterial strains. Physicians have reacted positively to this program, requesting additional information from Health Net to distribute directly to their patients.

By talking candidly with members, providing information, improving the flow and speed of communications and working collaboratively with partners, Health Net is adding value to health care. In addition, a sensible Patients' Bill of Rights law that maintains quality, access and affordability as its basic tenets - and provides consumers with a quick and fair process for resolving disputes - will help increase consumer confidence in the industry and in the good work performed by 11,000 Health Net associates.

ENTERPRISING

FROM LEFT TO RIGHT: NEW VENTURES GROUP REPRESENTATIVES
KATHLEEN RICHARD, STEVE SELL, PAUL GILBERTSON

Based just miles from California's Silicon Valley, Health Net's New Ventures Group is working around-the-clock to develop new technological tools to streamline health care processes, empower consumers and reduce administrative tasks for its customers. Formed in late 1999 with just three associates, the New Ventures Group today employs more than 80 - and continues to grow. Led by Gary Velasquez, the group is working on several key Internet-based health care initiatives that focus on consumers, providers, employers and the company's own associates. Its goal is simple: Reinvent Health Net's business models and processes through the use of technology, innovation, external partnerships and executable solutions, enabling Health Net to create value for customers, partners and stockholders.

Transforming the Business -

Technology is revolutionizing the world and transforming the way companies conduct business. While most industries embraced technology years ago, the managed health care industry was slow to respond - until just recently.

Over the course of 2000, Health Net made great strides in developing technological tools to simplify processes, empower consumers with information and reduce overall transaction costs.

Leading the technology charge for Health Net in 2000 was the company's New Ventures Group. Last year, the Group introduced several key initiatives that will serve as the harbinger in transforming the way Health Net does business.

Empowering Consumers -

In late 2000, Health Net launched Questium, one of the first consumer Web sites to link health plan members directly with personal health benefit information. Among its many features, Questium allows consumers to view their own benefit plans, co-payment information and out-of-pocket maximums online, anytime.

Questium 2.0, which will be released in mid-2001, will let members refill mail-order prescriptions online and view individual medical histories from health plan records over a secure Internet site. In addition to providing consumers with information right at their fingertips, Questium will allow the company to meet several "access to information" requirements of the Health Insurance Portability and Accountability Act of 1996, scheduled to become effective in 2003.

Connecting Providers -

From its connectivity pilot project in Connecticut to its involvement in a national effort called MedUnite, Health Net is using technology to help cut red tape and reduce administrative burdens for hospitals, physicians and administrative staff.

MedUnite, an industry-sponsored provider connectivity initiative, will allow physicians, health care providers and insurers to use a standardized approach to conduct real-time, paper-based transactions - such as eligibility verification, claims submission and status, and referrals and authorizations - via the Internet. In doing so, transaction costs can be greatly reduced for both physicians and health plans.

While MedUnite was incubated by Health Net and its New Ventures Group, it is now a stand-alone organization based in San Diego, Calif. In addition to Health Net, MedUnite is funded by the following founding investors:

Aetna, Anthem, CIGNA, Oxford Health Plans, PacifiCare Health Systems, Inc. and WellPoint Health Networks. MedUnite will be introduced to doctors through pilot projects in the East and the West during the first half of 2001.

PROVIDING THE TOOLS - The New Ventures Group is working on several online enrollment, eligibility and billing solutions for its customers. During the first quarter of 2001, the company's government contracts subsidiary, Health Net Federal Services, announced an Internet-based enrollment and eligibility system for its TRICARE line of business, which includes more than 1.5 million beneficiaries.

In addition, the company is working on other tools that will allow employer groups to conduct administrative activities over the Internet. The New Ventures Group is partnering with major technology partners to develop online tools that simplify and expedite the enrollment, eligibility and billing processes. This will allow customers to conduct transactions in real time, while keeping Health Net's enrollment and billing records accurate and up-to-date.

NETWORKING ASSOCIATES - During the latter part of 2000, the New Ventures Group began work on an enterprise-wide portal for its own 11,000 associates. The portal, which serves as the company's internal Web site, will, for the first time in Health Net's history, electronically connect all of its associates located throughout the country at more than 200 sites.

Called "Health Net Connect," the portal will be released in several phases throughout 2001. In addition to linking all associates and subsidiaries, the portal will provide associates with a broad range of information that supports critical business processes, enhances communication, eliminates bureaucracy and improves productivity.

INVESTING IN THE FUTURE - Through its key e-business initiatives, Health Net is making a significant investment in technology - and in the future of the company. Providing business partners and associates with the tools to simplify and expedite processes and improve the flow of information allows Health Net to provide better service to its customers, reduce administrative and transaction costs and create value for customers and stockholders.

2000 FINANCIAL REVIEW

Market for Registrant's Common Equity and Related Stockholder Matters

The following table sets forth the high and low sales prices of the Company's Class A Common Stock, par value $.001 per share (the "Class A Common Stock"), on the New York Stock Exchange, Inc. ("NYSE") since January 4, 1999.

	High	Low
Calendar Quarter – 1999		
First Quarter	12 7/16	7 11/16
Second Quarter	20 1/16	10 13/16
Third Quarter	16 15/16	8 7/8
Fourth Quarter	10 1/2	6 1/4
Calendar Quarter – 2000		
First Quarter	11 11/16	7 5/8
Second Quarter	14 11/16	7 11/16
Third Quarter	18 9/16	13 1/4
Fourth Quarter	26 15/16	15 9/16
Calendar Quarter – 2001		
First Quarter		
(through March 7, 2001)	26 3/16	18

On March 7, 2001, the last reported sales price per share of the Class A Common Stock was $21.08 per share.

DIVIDENDS

No dividends have been paid by the Company during the preceding two fiscal years. The Company has no present intention of paying any dividends on its Common Stock.

The Company is a holding company and, therefore, its ability to pay dividends depends on distributions received from its subsidiaries, which are subject to regulatory net worth requirements and certain additional state regulations which may restrict the declaration of dividends by HMOs, insurance companies and licensed managed health care plans. The payment of any dividend is at the discretion of the Company's Board of Directors and depends upon the Company's earnings, financial position, capital requirements and such other factors as the Company's Board of Directors deems relevant.

Under the Credit Agreement entered into on July 8, 1997 with Bank of America as agent, the Company cannot declare or pay cash dividends to its stockholders or purchase, redeem or otherwise acquire shares of its capital stock or warrants, rights or options to acquire such shares for cash except to the extent permitted under such Credit Agreement as described in the Company's Annual Report on Form 10-K.

HOLDERS

As of March 7, 2001, there were approximately 1,700 holders of record of Class A Common Stock.

Management's Discussion and Analysis of Financial Condition and Results of Operations

Health Net, Inc. (formerly named Foundation Health Systems, Inc.) (together with its subsidiaries, the "Company") is an integrated managed care organization which administers the delivery of managed health care services. Through its subsidiaries, the Company offers group, individual, Medicaid and Medicare health maintenance organization ("HMO"), point of service ("POS") and preferred provider organization ("PPO") plans; government-sponsored managed care plans; and managed care products related to administration and cost containment, behavioral health, dental, vision and pharmaceutical products and other services.

The Company currently operates within two segments: Health Plan Services and Government Contracts/Specialty Services. The Health Plan Services segment consists of two regional divisions: Western Division (Arizona, California and Oregon) and Eastern Division (Connecticut, Florida, New Jersey, New York and Pennsylvania). During 1999, the Health Plan Services segment consisted of four regional divisions:

- Arizona (Arizona and Utah)
- California (encompassing only the State of California)
- Central (Colorado, Florida, Idaho, Louisiana, New Mexico, Oklahoma, Oregon, Texas and Washington)
- Northeast (Connecticut, New Jersey, New York, Ohio, Pennsylvania and West Virginia).

During 1999, the Company either divested its health plans or entered into arrangements to transition the membership of its health plans in the states of Colorado, Idaho, Louisiana, New Mexico, Oklahoma, Texas, Utah and Washington. Effective January 1, 2000, as a result of such divestitures, the Company consolidated and reorganized its Health Plan Services segment into its two current regional divisions.

In 2000, the Company decided to exit the Ohio, West Virginia and Western Pennsylvania markets and provided notice of its intention to withdraw from these service areas to the appropriate regulators. As of February 2001, the Company no longer had any members in such markets.

In January 2001, the Company entered into a definitive agreement to sell its Florida health plan, Foundation Health, a Florida Health Plan, Inc., to Florida Health Plan Holdings II, LLC for $48 million consisting of $23 million in cash and $25 million in a secured five-year note bearing 8% interest. At December 31, 2000, the Florida health plan had total membership of approximately 169,700 members. The sale transaction is expected to close by June 30, 2001, subject to regulatory approvals and other customary conditions of closing.

The Company is one of the largest managed health care companies in the United States, with about 4.0 million at-risk and administrative services only ("ASO") members in its Health Plan Services segment. The Company also owns health and life insurance companies licensed to sell PPO, POS and indemnity products, as well as certain auxiliary non-health products such as life and accidental death and disability insurance in 35 states and the District of Columbia.

The Government Contracts/Specialty Services segment administers large, multi-year managed health care government contracts. Certain components of these contracts, including administration and assumption of health care risk, are subcontracted to affiliated and unrelated third parties. The Company administers health care programs covering approximately 1.5 million eligible individuals under TRICARE. The Company has three TRICARE contracts that cover Alaska, Arkansas, California, Hawaii, Oklahoma, Oregon, Washington and parts of Arizona, Idaho, Louisiana and Texas. Through this segment, the Company also offers behavioral health, dental and vision services as well as managed care products related to bill review, administration and cost containment for hospitals, health plans and other entities.

This discussion and analysis and other portions of this 2000 Annual Report to Stockholders and the Company's Annual Report on Form 10-K for the year ended December 31, 2000 ("Form 10-K") contain "forward-looking statements" within the meaning of Section 21E of the Securities Exchange Act of 1934, as amended, and Section 27A of the Securities Act of 1933, as amended, that involve risks and uncertainties. All statements other than statements of historical information provided herein may be deemed to be forward-looking statements. Without limiting the foregoing, the words "believes," "anticipates," "plans," "expects" and similar expressions are intended to identify forward-looking statements. Factors that could cause actual results to differ materially from those reflected in the forward-looking statements include, but are not limited to, the risks discussed in the "Cautionary Statements" section and other sections included in the Company's Form 10-K and

within the Company's filings with the Securities and Exchange Commission ("SEC"). Readers are cautioned not to place undue reliance on these forward-looking statements, which reflect management's analysis, judgment, belief or expectation only as of the date hereof. Except as required by law, the Company undertakes no obligation to publicly revise these forward-looking statements to reflect events or circumstances that arise after the date hereof.

RESULTS OF OPERATIONS

CONSOLIDATED OPERATING RESULTS

The Company's net income for the year ended December 31, 2000 was $163.6 million, or $1.33 per diluted share, compared to net income for the same period in 1999 of $142.4 million, or $1.16 per diluted share. The Company's net loss for the year ended December 31, 1998 was $165.2 million, or $1.35 per diluted share.

The table below and the discussion that follows summarize the Company's performance in the last three fiscal years. Certain 1999 and 1998 amounts have been reclassified to conform to the 2000 presentation. These reclassifications did not affect net income or loss or earnings or losses per share.

	Year Ended December 31,		
(Amounts in thousands, except per member per month data)	2000	1999	1998
REVENUES:			
Health plan services premiums	$7,351,098	$7,031,055	$7,124,161
Government contracts/Specialty services	1,623,158	1,529,855	1,411,267
Investment and other income	102,299	86,977	93,441
Total revenues	9,076,555	8,647,887	8,628,869
EXPENSES:			
Health plan services	6,242,282	5,950,002	6,090,472
Government contracts/Specialty services	1,080,407	1,002,893	924,075
Selling, general and administrative	1,296,881	1,301,743	1,413,771
Depreciation	67,260	70,010	78,951
Amortization	38,639	42,031	49,142
Interest	87,930	83,808	92,159
Asset impairment, merger, restructuring and other costs	–	11,724	240,053
Net loss (gain) on sale of businesses and properties	409	(58,332)	(5,600)
Total expenses	8,813,808	8,403,879	8,883,023
Income (loss) from operations before income tax provision and cumulative effect of a change in accounting principle	262,747	244,008	(254,154)
Income tax provision (benefit)	99,124	96,226	(88,996)
Income (loss) before cumulative effect of a change in accounting principle	163,623	147,782	(165,158)
Cumulative effect of a change in accounting principle, net of tax	–	(5,417)	–
Net income (loss)	$ 163,623	$ 142,365	$ (165,158)
Health plan services medical care ratio ("MCR")	84.9%	84.6%	85.5%
Government contracts/Specialty services MCR	66.6%	65.6%	65.5%
Administrative (SG&A + Depreciation) Ratio	15.2%	16.0%	17.5%
Health plan premiums per member per month	$ 156.71	$ 138.76	$ 128.98
Health plan services per member per month	$ 133.07	$ 117.42	$ 110.27

Enrollment Information

The table below summarizes the Company's enrollment information for the last three fiscal years. Total at-risk insured enrollment decreased by approximately 1% to approximately 3.9 million members at December 31, 2000 compared to enrollment at December 31, 1999. Total insured enrollment decreased by approximately 5% to approximately 4.0 million members at December 31, 1999 compared to enrollment at December 31, 1998.

Year Ended December 31, *(Amounts in thousands)*	2000	Percent Change	1999	Percent Change	1998
Health Plan Services:					
Commercial	2,996	4.7%	2,862	(4.9)%	3,008
Medicare	272	3.8%	262	(15.2)%	309
Medicaid	666	7.6%	619	11.5%	555
Continuing plans	3,934	5.1%	3,743	(3.3)%	3,872
Discontinued plans	3	(98.7)%	228	(30.3)%	327
Total Health Plan Services	3,937	(0.9)%	3,971	(5.4)%	4,199
Government Contracts:					
TRICARE and Indemnity	562	(12.7)%	644	(17.9)%	784
TRICARE HMO	901	5.8%	852	8.8%	783
Total Government Contracts	1,463	(2.2)%	1,496	(4.5)%	1,567
ASO	83	(19.4)%	103	(33.1)%	154

Excluding the discontinued plans, commercial membership increased 5% to approximately 3.0 million members at December 31, 2000 compared to 2.9 million members at December 31, 1999 due to membership increases in California primarily in point of service ("POS") products and in Connecticut and New York in small, mid-market, and large groups.

Excluding the discontinued plans, Medicare membership increased 4% to 272,000 members at December 31, 2000 compared to 262,000 members at December 31, 1999 primarily due to growth in Florida and California.

Excluding the discontinued plans, Medicaid membership increased 8% to 666,000 members at December 31, 2000 compared to 619,000 members at December 31, 1999 primarily due to increases in the Healthy Families program in California.

Excluding the discontinued plans, commercial membership declined 5% to 2.9 million members at December 31, 1999 compared to 3.0 million members at December 31, 1998 primarily due to membership losses attributable to planned membership attrition from rigorous pricing actions.

Excluding the discontinued plans, Medicare membership declined 15% to 262,000 members at December 31, 1999 compared to 309,000 members at December 31, 1998 primarily due to the Company exiting certain unprofitable counties primarily in its Northeast health plans.

Excluding the discontinued plans, Medicaid membership increased 12% to 619,000 members at December 31, 1999 compared to 555,000 members at December 31, 1998 primarily due to increased sales in the Healthy Families program in California.

Government contracts covered approximately 1.5 million eligible individuals under the TRICARE program at December 31, 2000. Dependents of active-duty military personnel and retirees and their dependents are automatically eligible to receive benefits under the TRICARE program. Any changes in the enrollment reflect the timing of when the individuals become eligible.

HEALTH PLAN SERVICES PREMIUMS

Health Plan Services premiums increased $320.0 million or 5% for the year ended December 31, 2000 compared to the same period in 1999 primarily due to the following:

- Average commercial premium rate increases of 11%,
- Average Medicare premium rate increases of 14%, and
- Average Medicaid premium rate increases of 2%, partially offset by
- Net membership decrease of 0.9%.

Health Plan Services premiums decreased $93.1 million or 1% for the year ended December 31, 1999 compared to the same period in 1998 primarily due to enrollment in the Company's health plans declining by 228,000 members. 71,000 members were from divested health plans. This was partially offset by average premium rate increases of 8% for commercial product lines, 7% for Medicare product lines, and 5% for Medicaid product lines.

GOVERNMENT CONTRACTS/SPECIALTY SERVICES

Government Contracts/Specialty Services segment revenues increased $93.3 million or 6% for the year ended December 31, 2000 compared to the same period in 1999. The increase was primarily due to an increase in TRICARE revenues comprised of:

- Higher health care costs resulting in higher risk share revenues from the Government, and
- Increased change orders and bid price adjustments.

This increase in TRICARE revenues was primarily due to the continuing shift in health care utilization from military facilities to civilian facilities for the three

contracts the Company holds with the TRICARE programs for dependents of active-duty military personnel and retirees and their dependents.

Government Contracts/Specialty Services segment revenues increased $118.6 million or 8% for the year ended December 31, 1999 compared to the same period in 1998. The increase in Government Contracts/Specialty Services segment revenues was primarily due to increases in TRICARE revenues and continued growth in the Company's behavioral health network.

INVESTMENT AND OTHER INCOME

Investment and other income increased $15.3 million or 18% for the year ended December 31, 2000 compared to the same period in 1999. The increase was primarily due to an increase in the average yield rate combined with higher investable assets.

Investment and other income decreased $6.5 million or 7% for the year ended December 31, 1999 compared to the same period in 1998. The decrease was primarily due to divestiture of non-core plans during 1999.

HEALTH PLAN SERVICES MCR

Health Plan Services MCR increased to 84.9% for the year ended December 31, 2000 compared to 84.6% for the same period in 1999. This increase was primarily due to the following:

- An increase in the pharmacy costs for the majority of the health plans, and
- Higher fee-for-service medical costs from increased utilization of physician and hospital services.

The Health Plans Services MCR decreased to 84.6% for the year ended December 31, 1999 from 85.5% for the same period in 1998 primarily due to an increased focus on medical management.

GOVERNMENT CONTRACTS/SPECIALTY SERVICES MCR

The Government Contracts/Specialty Services MCR increased to 66.6% for the year ended December 31, 2000 as compared to 65.6% for the same period in 1999. This increase was primarily due to the following:

- Continued movement of health care services from military treatment facilities to civilian facilities which resulted in higher costs than originally specified in the contract, and
- Managed Health Network, the Company's behavioral health care subsidiary, increased benefit payments due to parity provisions instituted by certain states during the year ended December 31, 2000. These provisions require behavioral health service providers to offer the same level of services to all current health plan members.

The Government Contracts/Specialty Services MCR increased to 65.6% for the year ended December 31, 1999 as compared to 65.5% for the same period in 1998. This increase for 1999 was primarily due to the movement of health care services from military treatment facilities to civilian facilities which resulted in higher costs than originally specified in the contract.

SELLING, GENERAL AND ADMINISTRATIVE COSTS

The administrative expense ratio (SG&A and depreciation as a percentage of Health Plan Services revenues and Government Contracts/Specialty Services revenues) decreased to 15.2% for the year ended December 31, 2000 from 16.0% for the same period in 1999. This decrease was primarily attributable to:

- The Company's ongoing efforts to control its SG&A expenses,
- Improved efficiencies associated with consolidating certain administrative processing functions in the Western and Eastern Divisions, and
- Continued fixed cost savings from the 1999 disposition of certain non-core plans.

The administrative expense ratio decreased to 16.0% for the year ended December 31, 1999 from 17.5% for the same period in 1998. This decrease was primarily attributable to the Company's efforts to control its SG&A expenses and savings associated with consolidating certain health plans.

AMORTIZATION AND DEPRECIATION

Amortization and depreciation expense decreased by $6.1 million or 5% for the year ended December 31, 2000 from the same period in 1999. This decrease was primarily due to reductions of $7.6 million in goodwill and $17.5 million in properties and equipment as a result of divestitures of certain operations.

Amortization and depreciation expense decreased by $16.1 million or 13% for the year ended December 31, 1999 compared to the same period in 1998. This decrease was primarily due to a $61.2 million write-down of fixed assets in the fourth quarter of 1998 and impairment charges for goodwill in 1998 that amounted to $30.0 million. See "Asset Impairment, Merger, Restructuring and Other Costs" below and Note 15 to the consolidated financial statements.

INTEREST EXPENSE

Interest expense increased by $4.1 million or 5% for the year ended December 31, 2000 from the same period in 1999. This increase in interest expense reflects the higher average borrowing rate of 7.6% in 2000 compared to 7.2% in 1999. This increase in the average borrowing rate was partially offset by a reduction in the average revolving credit facility balance.

Interest expense decreased by $8.4 million or 9% for the year ended December 31, 1999 from the same period in 1998. This decrease was due to a net decline in the revolving credit borrowings primarily as a result of cash proceeds from divestitures.

ASSET IMPAIRMENT, MERGER, RESTRUCTURING AND OTHER COSTS

This section should be read in conjunction with Notes 14 and 15, and the tables contained therein, to the consolidated financial statements.

1999 Charges

During the fourth quarter of 1998, the Company initiated a formal plan to dispose of certain health plans of the Company's then Central Division included in the Company's Health Plan Services segment in accordance with its anticipated divestitures program. In this connection, the Company announced in 1999 its plan to close the Colorado regional processing center, terminate employees and transfer its operations to the Company's other administrative facilities. In addition, the Company also announced its plans to consolidate certain administrative functions in its Oregon and Washington health plan operations. During the year ended December 31, 1999, the Company recorded pretax charges for restructuring and other charges of $21.1 million (the "1999 Charges") and $6.2 million, respectively.

Severance and Benefit Related Costs – The 1999 Charges included $18.5 million for severance and benefit costs related to executives and operations employees at the Colorado regional processing center and operations employees at the Northwest health plans. The operations functions include premium accounting, claims, medical management, customer service, sales and other related departments. The 1999 Charges included the termination of a total of 773 employees. As of December 31, 2000, termination of the employees was completed and $17.2 million had been paid. There are no expected future cash outlays. Modifications to the initial estimate of $1.3 million were recorded during the year ended December 31, 1999.

Asset Impairment Costs – During the fourth quarter ended December 31, 1999, the Company recorded asset impairment costs totaling $6.2 million related to impairment of certain long-lived assets held for disposal.

Real Estate Lease Termination and Other Costs – The 1999 Charges included $2.6 million related to termination of real estate obligations and other costs to close the Colorado regional processing center.

The 1999 restructuring plan was completed as of December 31, 2000.

1998 Charges

In connection with the Company's 1998 restructuring plans, severance, asset impairment and other costs totaling $240.1 million were recorded during the year ended December 31, 1998. As of December 31, 1999, the 1998 restructuring plans were completed.

Severance and Benefit Related Costs – During the year ended December 31, 1998, the Company recorded severance costs of $21.2 million related to staff reductions in selected health plans and the corporate centralization and consolidation. This plan included the termination of 683 employees in seven geographic locations primarily relating to corporate finance and human resources functions and California operations. As of December 31, 1999, the termination of employees had been completed and $20.1 million had been recorded as severance under this plan.

FPA Medical Management – On July 19, 1998, FPA Medical Management, Inc. ("FPA") filed for bankruptcy protection under Chapter 11 of the Federal Bankruptcy Code. FPA, through its affiliated medical groups, provided services to approximately 190,000 of the Company's affiliated members in Arizona and California and also leased health care facilities from the Company. FPA has discontinued its medical group operations in these markets and the Company has made other arrangements for health care services to the Company's affiliated members. The FPA bankruptcy and related events and circumstances caused management to re-evaluate the decision to continue to operate the facilities and management determined to sell the 14 properties, subject to bankruptcy court approval. Management immediately commenced the sale process upon such determination. The estimated fair value of the assets held for disposal was determined based on the estimated sales prices less the related costs to sell the assets. Management believed that the net proceeds from a sale of the facilities would be inadequate to enable the Company to recover their carrying value. Based on management's best estimate of the net realizable values, the Company recorded charges totaling approximately $84.1 million. These charges were comprised of $63.0 million for real estate asset impairments, $10.0 million impairment adjustment of a note received as consideration in connection with the 1996 sale of the Company's physician practice management business and $11.1 million for other items. These other items included payments made to Arizona physician specialists totaling $3.4 million for certain obligations that FPA had assumed but was unable to pay due to its bankruptcy, advances to FPA to fund certain operating expenses totaling $3.0 million, and other various costs totaling $4.7 million. The carrying value of the assets held for disposal totaled $ 9.9 million at December 31, 2000. There have been no further adjustments to the carrying value of these assets held for disposal. As of December 31, 2000, 12 properties have been sold which has resulted in net gains of $5.0 million during 1999 and $3.6 million in 1998 which are included in net gains on sale of businesses and buildings. The remaining properties are expected to be sold during 2001. The effects of the suspension of real estate depreciation on the respective properties had an impact of approximately $2.0 million in 1998 and were immaterial during 2000 and 1999. The results of operations attributable to FPA real estate assets were immaterial during 1998, 1999 and 2000.

Asset Impairment and Other Charges – During the fourth quarter ended December 31, 1998, the Company recorded impairment and other charges totaling $118.4 million. Of this amount, $112.4 million related to impairment of certain long-lived assets held for disposal and $6 million related to the FPA bankruptcy.

Other Costs – The Company recorded other costs of $22.4 million which included the adjustment of amounts due from a third-party hospital system that filed for bankruptcy which were not related to the normal business of the Company totaling $18.6 million, and $3.8 million related to other items such as fees for consulting services from one of the Company's prior executives and costs related to exiting certain rural Medicare markets.

During 1999, modifications of $12.6 million to the initial estimates were recorded. These credits to the 1998 charges included: $10.7 million from reductions to asset impairment costs and $1.9 million from reductions to initially anticipated involuntary severance costs and other adjustments.

NET GAIN (LOSS) ON SALE OF BUSINESSES AND PROPERTIES

Net loss on sale of businesses and properties for the year ended December 31, 2000 was comprised of the following:

- Gain on sale of a building in California of $1.1 million, and
- Loss on sale of HMO operations in Washington due to purchase price adjustment of $1.5 million.

Net gain on sale of businesses and properties for the year ended December 31, 1999 was comprised of the following:

- Gain on sale of pharmacy benefits management operations of $60.6 million,
- Net loss on sale of non-core operations of $9.1 million, and
- Gain on sale of buildings of $6.8 million.

Gain on sale of businesses and properties for the year ended December 31, 1998 was comprised of a net gain on the sale of buildings of $4.4 million and a gain on the sale of certain call center operations of $1.2 million.

INCOME TAX PROVISION AND BENEFIT

The effective income tax rate was 37.7% for the year ended December 31, 2000 compared with 39.4% for the same period in 1999. The rate declined primarily due to tax minimization strategies and related to the Company's change in business mix after divestiture of non-core operations.

The effective income tax rate was 39.4% for the year ended December 31, 1999 compared with a tax benefit rate of 35.0% for the same period in 1998. The change was mainly due to non-deductible impairment charges incurred in 1998.

IMPACT OF INFLATION AND OTHER ELEMENTS

The managed health care industry is labor intensive and its profit margin is low; hence, it is especially sensitive to inflation. Increases in medical expenses or contracted medical rates without corresponding increases in premiums could have a material adverse effect on the Company.

Various federal and state legislative initiatives regarding the health care industry continue to be proposed during legislative sessions. If further health care reform or similar legislation is enacted, such legislation could impact the Company. Management cannot at this time predict whether any such initiative will be enacted and, if enacted, the impact on the financial condition or results of operations of the Company.

The Company's ability to expand its business is dependent, in part, on competitive premium pricing and its ability to secure cost-effective contracts with providers. Achieving these objectives is becoming increasingly difficult due to the competitive environment. In addition, the Company's profitability is dependent, in part, on its ability to maintain effective control over health care costs while providing members with quality care. Factors such as health care reform, regulatory changes, increased cost of medical services, utilization, new technologies and drugs, hospital costs, major epidemics and numerous other external influences may affect the Company's operating results. Accordingly, past financial performance is not necessarily a reliable indicator of future performance, and investors should not use historical records to anticipate results or future period trends.

The Company's HMO and insurance subsidiaries are required to maintain reserves to cover their estimated ultimate liability for expenses with respect to reported and unreported claims incurred. These reserves are estimates of future payments based on various assumptions. Establishment of appropriate reserves is an inherently uncertain process, and there can be no certainty that currently established reserves will prove adequate in light of subsequent actual experience, which in the past has resulted, and in the future could result, in loss reserves being too high or too low. The accuracy of these estimates may be affected by external forces such as changes in the rate of inflation, the regulatory environment, medical costs and other factors. Future loss development or governmental regulators could require reserves for prior periods to be increased, which would adversely impact earnings in future periods. In light of present facts and current legal interpretations, management believes that adequate provisions have been made for claims and loss reserves.

The Company's California HMO subsidiary contracts with providers in California primarily through capitation fee arrangements. The Company's other HMO subsidiaries contract with providers, to a lesser degree, in other areas through capitation fee arrangements. Under a capitation fee arrangement, the Company's subsidiary pays the provider a fixed amount per member on a regular basis and the provider accepts the risk of the frequency and cost of member utilization of services. The inability of providers to properly manage costs under capitation arrangements can result in financial instability of such providers. Any financial instability of capitated providers could lead to claims for unpaid health care against the Company's HMO subsidiaries, even though such subsidiaries have made their regular payments to the capitated providers. Depending on state law, the Company's HMO subsidiaries may or may not be liable for such claims. In California, the issue of whether HMOs are liable for unpaid provider claims has not been

definitively settled. The California agency that until July 1, 1999 acted as regulator of HMOs, had issued a written statement to the effect that HMOs are not liable for such claims. However, there is currently ongoing litigation on the subject among providers and HMOs, including the Company's California HMO subsidiary.

LIQUIDITY AND CAPITAL RESOURCES

Certain of the Company's subsidiaries must comply with minimum capital and surplus requirements under applicable state laws and regulations, and must have adequate reserves for claims. Certain subsidiaries must maintain ratios of current assets to current liabilities pursuant to certain government contracts. The Company believes it is in compliance with these contractual and regulatory requirements in all material respects.

The Company believes that cash from operations, existing working capital, lines of credit, and funds from planned divestitures of business are adequate to fund existing obligations, introduce new products and services, and continue to develop health care-related businesses. The Company regularly evaluates cash requirements for current operations and commitments, and for capital acquisitions and other strategic transactions. The Company may elect to raise additional funds for these purposes, either through additional debt or equity, the sale of investment securities or otherwise, as appropriate.

The Company's investment objective is to maintain safety and preservation of principal by investing in high-quality, investment grade securities while maintaining liquidity in each portfolio sufficient to meet the Company's cash flow requirements and attaining the highest total return on invested funds.

Government health care receivables are best estimates of payments that are ultimately collectible or payable. Since these amounts are subject to government audit, negotiation and appropriations, amounts ultimately collected may vary significantly from current estimates. Additionally, the timely collection of such receivables is also impacted by government audit and negotiation and could extend for periods beyond a year.

In December 2000, the Company's subsidiary, Health Net Federal Services, Inc., and the Department of Defense agreed to a settlement of approximately $389 million for outstanding receivables related to the Company's three TRICARE contracts and for the completed contract for the CHAMPUS Reform Initiative. Approximately $60 million of the settlement amount was received in December 2000. The majority of the remaining settlement that was received on January 5, 2001 reduced the amounts receivable under government contracts on the Company's balance sheets. The receivable items settled by this payment include change orders, bid price adjustments, equitable adjustments and claims. These receivables developed as a result of TRICARE health care costs rising faster than the forecasted health care cost trends used in the original contract bids, data revisions on formal contract adjustments, and routine contract changes for benefits. The settlement amount, after paying vendors, providers and amounts owed back to the government, will be applied to the continuing operating needs of the three TRICARE contracts and to reducing the outstanding balance of the notes payable.

In 1997, the Company purchased convertible and nonconvertible debentures of FOHP, Inc., a New Jersey corporation ("FOHP"), in the aggregate principal amounts of approximately $80.7 million and $24.0 million, respectively. In 1997 and 1998, the Company converted certain of the convertible debentures into shares of Common Stock of FOHP, resulting in the Company owning 99.6% of the outstanding common stock of FOHP. The nonconvertible debentures mature on December 31, 2002.

Effective January 1, 1999, Physicians Health Services of New Jersey, Inc., a New Jersey HMO wholly-owned by the Company, merged with and into First Option Health Plan of New Jersey ("FOHP-NJ"), a New Jersey HMO subsidiary of FOHP, and FOHP-NJ changed its name to Physicians Health Services of New Jersey, Inc. ("PHS-NJ"). Effective July 30, 1999, upon approval by the stockholders of FOHP at a special meeting, a wholly-owned subsidiary of the Company merged into FOHP and FOHP became a wholly-owned subsidiary of the Company. In connection with the merger, the former minority shareholders of FOHP are entitled to receive either $0.25 per share (the value per FOHP share as of December 31, 1998 as determined by an outside appraiser) or payment rights which entitle the holders to receive as much as $15.00 per payment right on or about July 1, 2001, provided certain hospital and other provider participation conditions are met. Also in connection with the merger, additional consideration of $2.25 per payment right will be paid to certain holders of the payment rights if PHS-NJ achieves certain annual returns on common equity and the participation conditions are met. As of December 31, 2000, the Company determined that it is probable that these payment rights would be paid on or about July 1, 2001. Accordingly, the Company recorded a current liability and a purchase price adjustment to goodwill of $33.7 million as of December 31, 2000.

OPERATING CASH FLOWS

Net cash provided by operating activities was $366.2 million at December 31, 2000 compared to $297.1 million at December 31, 1999. The increase in operating cash flows was due primarily to:

- Higher net income,
- Liabilities associated with the 1998 and 1999 restructuring plans eliminated by December 31, 2000, and
- Liabilities associated with plans sold in 1999 which were eliminated.

INVESTING ACTIVITIES

Net cash used in investing activities was $61.9 million for December 31, 2000 compared to net cash provided by investing activities of $163.4 million for December 31, 1999. This decrease was primarily due to proceeds from the sale in 1999 of certain businesses and buildings of $137.7 million.

In 1995, the Company entered into a five year tax retention operating lease for the construction of various health care centers and a corporate facility. Upon expiration in May 2000, the lease was extended for four months through September 2000 whereupon the Company settled its obligations under the agreement and purchased the leased properties which were comprised of three rental health care centers and a corporate facility for $35.4 million. The health care centers are held as investment rental properties and are included in other noncurrent assets. The corporate facility building is used in operations and included in property and equipment. The buildings are being depreciated over a remaining useful life of 35 years.

Throughout 2000 and the first quarter of 2001, the Company has provided funding in the amount of approximately $4.2 million in MedUnite, Inc., an independent company, funded and organized by seven major managed health care companies. MedUnite, Inc. is designed to provide on-line internet provider connectivity services including eligibility information, referrals, authorizations, claims submission and payment. The funded amounts are included in other noncurrent assets.

During 2000, the Company secured an exclusive e-business connectivity services contract from the Connecticut State Medical Society IPA, Inc. ("CSMS-IPA") for $15.0 million. CSMS-IPA is an association of medical doctors providing health care primarily in Connecticut. The amounts paid to CSMS-IPA for this agreement are included in other noncurrent assets.

FINANCING ACTIVITIES

Net cash used in financing activities was $268.1 million at December 31, 2000 compared to $213.9 million at December 31, 1999. This increase was primarily due to higher repayment of funds previously drawn under the Company's Credit Facility in 2000 compared to 1999 (as defined below), which was partially offset by additional drawings under the Credit Facility.

The Company has a $1.5 billion credit facility (the "Credit Facility") with Bank of America as Administrative Agent for the Lenders thereto, which was amended by a Letter Agreement dated as of March 27, 1998 and Amendments in April, July, and November 1998, March 1999 and September 2000 (the "Amendments"). All previous revolving credit facilities were terminated and rolled into the Credit Facility on July 8, 1997. At the election of the Company, and subject to customary covenants, loans are initiated on a bid or committed basis and carry interest at offshore or domestic rates, at the applicable LIBOR rate plus margin or the bank reference rate. Actual rates on borrowings under the Credit Facility vary, based on competitive bids and the Company's unsecured credit rating at the time of the borrowing. As of December 31, 2000, the Company was in compliance with the financial covenants of the Credit Facility, as amended by the Amendments. As of December 31, 2000, the maximum commitment level under the Credit Agreement was approximately $1.36 billion, of which approximately $590 million remained available. The total outstanding balance under the Credit Agreement was $766.5 million as of December 31, 2000. The Credit Facility expires in July 2002, but it may be extended under certain circumstances for two additional years.

The Company's subsidiaries must comply with certain minimum capital requirements under applicable state laws and regulations. The Company will, however, make contributions to its subsidiaries, as necessary, to meet risk-based capital requirements under state laws and regulations. The Company contributed $45.5 million to certain of its subsidiaries to meet capital requirements during the year ended December 31, 2000. As of December 31, 2000, the Company's subsidiaries were in compliance with minimum capital requirements.

In March 1998, the National Association of Insurance Commissioners adopted the Codification of Statutory Accounting Principles ("Codification"). The Codification, which is intended to standardize regulatory accounting and reporting to state insurance departments, was effective January 1, 2001. However, statutory accounting principles continue to be established by individual state laws and permitted practices. Certain states in which the Company conducts business required the adoption of Codification for the preparation of statutory financial statements effective January 1, 2001. The Company estimates that the adoption of Codification will reduce the statutory net worth of the Company's subsidiaries as of January 1, 2001 by approximately $1.2 million, which primarily relates to accounting principles regarding electronic data processing equipment, unpaid claims adjustments, provider receivables, accident and health premiums due and unpaid, and deferred income taxes. Such reduction may require the Company to contribute additional capital to its subsidiaries to satisfy minimum statutory net worth requirements.

Legislation has been or may be enacted in certain states in which the Company's subsidiaries operate imposing substantially increased minimum capital and/or statutory deposit requirements for HMOs in such states. Such statutory deposits may only be drawn upon under limited circumstances relating to the protection of policyholders.

As a result of the above requirements and other regulatory requirements, certain subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to the Company. Such restrictions, unless amended or waived, limit the use of any cash generated by these subsidiaries to pay obligations of the Company. The maximum amount of dividends which can be paid by the insurance company subsidiaries to the Company without prior approval of the insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. Management believes that as of December 31, 2000, all of the Company's health plans and insurance subsidiaries met their respective regulatory requirements.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

In December 2000, the Department of Health and Human Services ("DHHS") promulgated certain regulations under HIPAA related to the privacy of individually identifiable health information (protected health information or "PHI"). The new regulations require health plans, clearinghouses and providers to (a) comply with various requirements and restrictions related to the use, storage and disclosure of PHI, (b) adopt rigorous internal proce-

dures to protect PHI, and (c) enter into specific written agreements with business associates to whom PHI is disclosed. The regulations establish significant criminal penalties and civil sanctions for non-compliance. In addition, the regulations could expose the Company to additional liability for, among other things, violations by its business associates. In February 2001, the DHHS stated that the regulations in their current form would require compliance by April 2003. The Company believes that the costs required to comply with the regulations will be significant and may have a material adverse impact on the Company's business or results of operations.

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The Company is exposed to interest rate and market risk primarily due to its investing and borrowing activities. Market risk generally represents the risk of loss that may result from the potential change in the value of a financial instrument as a result of fluctuations in interest rates and in equity prices. Interest rate risk is a consequence of maintaining fixed income investments. The Company is exposed to interest rate risks arising from changes in the level or volatility of interest rates, prepayment speeds and/or the shape and slope of the yield curve. In addition, the Company is exposed to the risk of loss related to changes in credit spreads. Credit spread risk arises from the potential that changes in an issuer's credit rating or credit perception may affect the value of financial instruments.

The Company has several bond portfolios to fund reserves. The Company attempts to manage the interest rate risks related to its investment portfolios by actively managing the asset/liability duration of its investment portfolios. The overall goal for the investment portfolios is to provide a source of liquidity and support the ongoing operations of the Company's business units. The Company's philosophy is to actively manage assets to maximize total return over a multiple-year time horizon, subject to appropriate levels of risk. Each business unit has additional requirements with respect to liquidity, current income and contribution to surplus. The Company manages these risks by setting risk tolerances, targeting asset-class allocations, diversifying among assets and asset characteristics, and using performance measurement and reporting.

The Company uses a value-at-risk ("VAR") model, which follows a variance/covariance methodology, to assess the market risk for its investment portfolio. VAR is a method of assessing investment risk that uses standard statistical techniques to measure the worst expected loss in the portfolio over an assumed portfolio disposition period under normal market conditions. The determination is made at a given statistical confidence level.

The Company assumed a portfolio disposition period of 30 days with a confidence level of 95 percent for the 2000 computation of VAR. The computation further assumes that the distribution of returns is normal. Based on such methodology and assumptions, the computed VAR was approximately $2.3 million as of December 31, 2000.

The Company's calculated value-at-risk exposure represents an estimate of reasonably possible net losses that could be recognized on its investment portfolios assuming hypothetical movements in future market rates and are not necessarily indicative of actual results which may occur. It does not represent the maximum possible loss nor any expected loss that may occur, since actual future gains and losses will differ from those estimated, based upon actual fluctuations in market rates, operating exposures, and the timing thereof, and changes in the Company's investment portfolios during the year. The Company, however, believes that any loss incurred would be offset by the effects of interest rate movements on the respective liabilities, since these liabilities are affected by many of the same factors that affect asset performance; that is, economic activity, inflation and interest rates, as well as regional and industry factors.

In addition, the Company has some interest rate market risk due to its borrowings. Notes payable, capital leases and other financing arrangements totaled $766 million at December 31, 2000 with a related average interest rate of 7.5% (which interest rate is subject to change pursuant to the terms of the Credit Facility). See a description of the Credit Facility under "Liquidity and Capital Resources."

The following table presents the expected cash outflows of market risk sensitive debt obligations at December 31, 2000. These cash outflows include both expected principal and interest payments consistent with the terms of the outstanding debt as of December 31, 2000.

(Amounts in thousands)	2001	2002	2003	2004	2005	Beyond	Total
Long-term floating rate borrowing:							
Principal	$ –	$766,450	$ –	$ –	$ –	$ –	$766,450
Interest	55,725	27,860	–	–	–	–	83,585
Total cash outflow	$55,725	$794,310	$ –	$ –	$ –	$ –	$850,035

Report of the Audit Committee of the Board of Directors of Health Net, Inc.

The Board of Directors of the Company addresses its oversight responsibility for the consolidated financial statements through its Audit Committee (the "Committee"). The Committee currently consists of Gov. George Deukmejian, Thomas T. Farley, Richard J. Stegemeier (Chairman), and Bruce G. Willison, each of whom is an independent outside director.

In fulfilling its responsibilities in 2000, the Committee reviewed the overall scope of the independent auditors' audit plan and reviewed the independent auditors' non-audit services to the Company. The Committee also exercised oversight responsibilities over various financial and regulatory matters.

The Committee's meetings are designed to facilitate open communication between the independent auditors and Committee members. To ensure auditor independence, the Committee meets privately with both the independent auditors and also with the chief auditor of the Company's Internal Audit Department, thereby providing for full and free access to the Committee.

Richard J. Stegemeier
Audit Committee Chairman
March 2, 2001

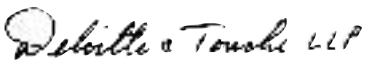
Report of Independent Auditors

To the Board of Directors and Stockholders of
Health Net, Inc.
Woodland Hills, California

We have audited the accompanying consolidated balance sheets of Health Net, Inc. and subsidiaries (the "Company") as of December 31, 2000 and 1999, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2000. These financial statements are the responsibility of the Company's management. 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 of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Health Net, Inc. and subsidiaries at December 31, 2000 and 1999, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2000 in conformity with accounting principles generally accepted in the United States of America.



Los Angeles, California
February 20, 2001

Consolidated Balance Sheets

Health Net, Inc.

(Amounts in thousands)	December 31, 2000	1999
ASSETS		
Current Assets:		
Cash and cash equivalents	$1,046,735	$1,010,539
Investments – available for sale	486,902	456,603
Premiums receivable, net of allowance for doubtful accounts (2000 – $19,822; 1999 – $21,937)	174,654	149,992
Amounts receivable under government contracts	334,187	290,329
Deferred taxes	141,752	209,037
Reinsurance and other receivables	141,140	153,427
Other assets	74,184	77,866
Total current assets	2,399,554	2,347,793
Property and equipment, net	296,009	280,729
Goodwill and other intangible assets, net	863,419	909,586
Other noncurrent assets	111,134	158,373
Total Assets	$3,670,116	$3,696,481
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Reserves for claims and other settlements	1,242,389	1,138,801
Unearned premiums	238,571	224,381
Notes payable and capital leases	49	1,256
Amounts payable under government contracts	972	43,843
Accounts payable and other liabilities	329,100	322,048
Total current liabilities	1,811,081	1,730,329
Notes payable and capital leases	766,450	1,039,352
Deferred taxes	8,635	5,624
Other noncurrent liabilities	22,819	29,977
Total Liabilities	2,608,985	2,805,282
Commitments and contingencies		
Stockholders' Equity:		
Preferred stock ($0.001 par value, 10,000 shares authorized, none issued and outstanding)	–	–
Class A common stock ($0.001 par value, 350,000 shares authorized; issued 2000 – 125,994; 1999 – 123,429)	126	124
Class B non-voting convertible common stock ($0.001 par value, 30,000 shares authorized; issued and outstanding 2000 – 0; 1999 – 2,138)	–	2
Additional paid-in capital	649,166	643,372
Treasury Class A common stock, at cost (2000 – 3,194 shares; 1999 – 3,194 shares)	(95,831)	(95,831)
Retained earnings	511,224	347,601
Accumulated other comprehensive loss	(3,554)	(4,069)
Total Stockholders' Equity	1,061,131	891,199
Total Liabilities and Stockholders' Equity	$3,670,116	$3,696,481

See accompanying notes to consolidated financial statements.

Consolidated Statements of Operations

Health Net, Inc.

(Amounts in thousands, except per share data)	Year Ended December 31, 2000	1999	1998
REVENUES			
Health plan services premiums	$7,351,098	$7,031,055	$7,124,161
Government contracts/Specialty services	1,623,158	1,529,855	1,411,267
Investment and other income	102,299	86,977	93,441
Total revenues	9,076,555	8,647,887	8,628,869
EXPENSES			
Health plan services	6,242,282	5,950,002	6,090,472
Government contracts/Specialty services	1,080,407	1,002,893	924,075
Selling, general and administrative	1,296,881	1,301,743	1,413,771
Depreciation	67,260	70,010	78,951
Amortization	38,639	42,031	49,142
Interest	87,930	83,808	92,159
Asset impairment, merger, restructuring and other costs	–	11,724	240,053
Net loss (gain) on sale of businesses and properties	409	(58,332)	(5,600)
Total expenses	8,813,808	8,403,879	8,883,023
Income (loss) from operations before income taxes and cumulative effect of a change in accounting principle	262,747	244,008	(254,154)
Income tax provision (benefit)	99,124	96,226	(88,996)
Income (loss) before cumulative effect of a change in accounting principle	163,623	147,782	(165,158)
Cumulative effect of a change in accounting principle, net of tax	–	(5,417)	–
Net income (loss)	$ 163,623	$ 142,365	$ (165,158)
Basic earnings (loss) per share:			
Income (loss) from operations	$ 1.34	$ 1.21	$ (1.35)
Cumulative effect of a change in accounting principle	–	(0.05)	–
Net	$ 1.34	$ 1.16	$ (1.35)
Diluted earnings (loss) per share:			
Income (loss) from operations	$ 1.33	$ 1.21	$ (1.35)
Cumulative effect of a change in accounting principle	–	(0.05)	–
Net	$ 1.33	$ 1.16	$ (1.35)
Weighted average shares outstanding:			
Basic	122,471	122,289	121,974
Diluted	123,453	122,343	121,974

See accompanying notes to consolidated financial statements.

Consolidated Statements of Stockholders' Equity

Health Net, Inc.

	Common Stock				Additional
	Class A		Class B		Paid-in
(Amounts in thousands)	Shares	Amount	Shares	Amount	Capital
Balance at January 1, 1998	114,449	$115	10,298	$10	$628,610
Comprehensive income (loss):					
Net loss					
Change in unrealized depreciation on investments, net of tax of $11					
Total comprehensive income (loss)	–	–	–	–	–
Exercise of stock options including related tax benefit	497	1			9,584
Conversion of Class B to Class A	5,250	5	(5,250)	(5)	
Employee stock purchase plan	166				3,625
Balance at December 31, 1998	120,362	121	5,048	5	641,819
Comprehensive income:					
Net income					
Change in unrealized depreciation on investments, net of tax of $2,159					
Total comprehensive income	–	–	–	–	–
Exercise of stock options including related tax benefit	5				
Conversion of Class B to Class A	2,910	3	(2,910)	(3)	
Employee stock purchase plan	152				1,553
Balance at December 31, 1999	123,429	124	2,138	2	643,372
Comprehensive income:					
Net income					
Change in unrealized depreciation on investments, net of tax of $343					
Total comprehensive income	–	–	–	–	–
Exercise of stock options including related tax benefit	314				4,683
Conversion of Class B to Class A	2,138	2	(2,138)	(2)	
Employee stock purchase plan	113				1,111
Balance at December 31, 2000	125,994	$126	–	$ –	$649,166

See accompanying notes to consolidated financial statements.

Consolidated Statements of Stockholders' Equity (continued)

Health Net, Inc.

(Amounts in thousands)	Common Stock Held in Treasury Shares	Common Stock Held in Treasury Amount	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total
Balance at January 1, 1998	(3,194)	$(95,831)	$370,394	$(7,324)	$895,974
Comprehensive income (loss):					
Net loss			(165,158)		(165,158)
Change in unrealized depreciation on investments, net of tax of $11				16	16
Total comprehensive income (loss)	–	–	(165,158)	16	(165,142)
Exercise of stock options including related tax benefit					9,585
Conversion of Class B to Class A					–
Employee stock purchase plan					3,625
Balance at December 31, 1998	(3,194)	(95,831)	205,236	(7,308)	744,042
Comprehensive income:					
Net income			142,365		142,365
Change in unrealized depreciation on investments, net of tax of $2,159				3,239	3,239
Total comprehensive income	–	–	142,365	3,239	145,604
Exercise of stock options including related tax benefit					–
Conversion of Class B to Class A					–
Employee stock purchase plan					1,553
Balance at December 31, 1999	(3,194)	(95,831)	347,601	(4,069)	891,199
Comprehensive income:					
Net income			163,623		163,623
Change in unrealized depreciation on investments, net of tax of $343				515	515
Total comprehensive income	–	–	163,623	515	164,138
Exercise of stock options including related tax benefit					4,683
Conversion of Class B to Class A					–
Employee stock purchase plan					1,111
Balance at December 31, 2000	(3,194)	$(95,831)	$511,224	$(3,554)	$1,061,131

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

Health Net, Inc.

(Amounts in thousands)	Year Ended December 31, 2000	1999	1998
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income (loss)	$ 163,623	$ 142,365	$(165,158)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Amortization and depreciation	105,899	112,041	128,093
Net loss (gain) on sale of businesses and properties	409	(58,332)	(5,600)
Cumulative effect of a change in accounting principle	–	5,417	–
Impairment of assets	–	11,724	159,066
Other changes	10,035	5,648	15,041
Changes in assets and liabilities, net of effects of dispositions:			
Premiums receivable and unearned premiums	(10,472)	(8,973)	38,569
Other assets	105,659	63,902	(69,671)
Amounts receivable/payable under government contracts	(86,729)	5,130	(58,000)
Reserves for claims and other settlements	103,588	167,084	(6,416)
Accounts payable and other liabilities	(25,849)	(148,878)	64,943
Net cash provided by operating activities	366,163	297,128	100,867
CASH FLOWS FROM INVESTING ACTIVITIES:			
Sales or maturities of investments	304,523	642,150	727,435
Purchase of investments	(253,141)	(606,350)	(697,472)
Net purchases of property and equipment	(86,853)	(36,592)	(147,782)
Sale of net assets of discontinued operations	–	–	257,100
Proceeds from sale of businesses and properties	3,505	137,728	–
Other	(29,943)	26,486	7,682
Net cash (used in) provided by investing activities	(61,909)	163,422	146,963
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from exercise of stock options and employee stock purchases	5,794	1,553	13,209
Proceeds from issuance of notes payable and other financing arrangements	250,033	221,276	155,575
Repayment of debt and other non-current liabilities	(523,885)	(436,705)	(212,109)
Net cash used in financing activities	(268,058)	(213,876)	(43,325)
Net increase in cash and cash equivalents	36,196	246,674	204,505
Cash and cash equivalents, beginning of year	1,010,539	763,865	559,360
Cash and cash equivalents, end of year	$1,046,735	$1,010,539	$ 763,865
SUPPLEMENTAL CASH FLOWS DISCLOSURE:			
Interest paid	$87,023	$85,212	$85,981
Income taxes paid (refunded)	9,694	6,106	(87,799)
SUPPLEMENTAL SCHEDULE OF NON-CASH INVESTING AND FINANCING ACTIVITIES:			
Capital lease obligations	–	–	$2,530
Notes and stocks received on sale of businesses	–	22,909	–
Conversion of FOHP convertible debentures to equity	–	–	1,197

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

NOTE 1 – Description of Business

On November 3, 2000, the Company changed its name from Foundation Health Systems, Inc. to Health Net, Inc. and changed its ticker symbol on the New York Stock Exchange (effective November 6, 2000) from "FHS" to "HNT." The Company accomplished the name change by merging a wholly-owned subsidiary, HNI Shell, Inc., with and into the Company and, in connection with such merger, amending its Fourth Amended and Restated Certificate of Incorporation to change the Company's name to Health Net, Inc.

The current operations of Health Net, Inc. (the "Company" or "HNT") are a result of the April 1, 1997 merger transaction (the "FHS Combination") involving Health Systems International, Inc. ("HSI") and Foundation Health Corporation ("FHC"). Pursuant to the FHS Combination, FH Acquisition Corp., a wholly-owned subsidiary of HSI ("Merger Sub"), merged with and into FHC and FHC survived as a wholly-owned subsidiary of HSI, which changed its name to "Foundation Health Systems, Inc." and thereby became the Company. Pursuant to the Agreement and Plan of Merger (the "Merger Agreement") that evidenced the FHS Combination, FHC stockholders received 1.3 shares of the Company's Class A Common Stock for every share of FHC common stock held, resulting in the issuance of approximately 76.7 million shares of the Company's Class A Common Stock to FHC stockholders. The shares of the Company's Class A Common Stock issued to FHC's stockholders in the FHS Combination constituted approximately 61% of the outstanding stock of the Company after the FHS Combination and the shares held by the Company's stockholders prior to the FHS Combination (i.e. the prior stockholders of HSI) constituted approximately 39% of the outstanding stock of the Company after the FHS Combination.

The FHS Combination was accounted for as a pooling of interests for accounting and financial reporting purposes. The pooling of interests method of accounting is intended to present, as a single interest, two or more common stockholder interests which were previously independent and assumes that the combining companies have been merged from inception.

The Company is an integrated managed care organization which administers the delivery of managed health care services through two segments: Health Plan Services and Government Contracts/Specialty Services. Through its subsidiaries, the Company offers group, individual, Medicaid and Medicare health maintenance organization ("HMO"), point of service ("POS") and preferred provider organization ("PPO") plans; government sponsored managed care plans; and managed care products related to administration and cost containment, behavioral health, dental, vision and pharmaceutical products and other services.

During 1999, the Health Plan Services segment consisted of four regional divisions: Arizona (Arizona and Utah), California (encompassing only the State of California), Central (Colorado, Florida, Idaho, Louisiana, New Mexico, Oklahoma, Oregon, Texas and Washington) and Northeast (Connecticut, New Jersey, New York, Ohio, Pennsylvania and West Virginia). During 1999, the Company either divested its health plans or entered into arrangements to transition the membership of its health plans in the states of Colorado, Idaho, Louisiana, New Mexico, Oklahoma, Texas, Utah and Washington. Effective January 1, 2000, as a result of such divestitures, the Company consolidated and reorganized its Health Plan Services segment into two regional divisions, the Eastern Division (Connecticut, Florida, New Jersey, New York, Ohio, Pennsylvania and West Virginia) and the Western Division (Arizona, California and Oregon). The Company is one of the largest managed health care companies in the United States, with approximately 4.0 million at-risk and administrative services only ("ASO") members in its Health Plan Services segment. The Company also owns health and life insurance companies licensed to sell insurance in 35 states and the District of Columbia.

The Government Contracts/Specialty Services segment administers large, multi-year managed care government contracts. This segment subcontracts to affiliated and unrelated third parties the administration and health care risk of parts of these contracts and currently administers health care programs covering 1.5 million eligible individuals under TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS")). The Company has three TRICARE contracts that cover Alaska, Arkansas, California, Hawaii, Oklahoma, Oregon and Washington, and parts of Arizona, Idaho, Louisiana and Texas. This segment also offers behavioral health, dental, vision, and pharmaceutical products and services as well as managed care products related to bill review, administration and cost containment for hospitals, health plans and other entities.

NOTE 2 - Summary of Significant Accounting Policies

Consolidation and Basis of Presentation

The consolidated financial statements include the accounts of the Company and its wholly-owned and majority-owned subsidiaries. All significant intercompany transactions have been eliminated in consolidation.

Reclassifications

Certain amounts in the 1999 and 1998 consolidated financial statements and notes have been reclassified to conform to the 2000 presentation. The reclassifications have no effect on net earnings or losses or stockholders' equity as previously reported.

Revenue Recognition

Health plan services premium revenues include HMO, POS and PPO premiums from employer groups and individuals and from Medicare recipients who have purchased supplemental benefit coverage, which premiums are based on a predetermined prepaid fee, Medicaid revenues based on multi-year contracts to provide care to Medicaid recipients, and revenue under Medicare risk contracts to provide care to enrolled Medicare recipients. Revenue is recognized in the month in which the related enrollees are entitled to health care services. Premiums collected in advance are recorded as unearned premiums.

Government contracts revenues are recognized in the month in which the eligible beneficiaries are entitled to health care services. Government contracts also contain cost and performance incentive provisions which adjust the contract price based on actual performance, and revenue under government contracts is subject to price adjustments attributable to inflation and other factors. The effects of these adjustments are recognized on a monthly basis, although the final determination of these amounts could extend significantly beyond the period during which the services were provided. Amounts receivable under government contracts are comprised primarily of estimated amounts receivable under these cost and performance incentive provisions, price adjustments, and change orders for services not originally specified in the contracts. These receivables develop as a result of TRICARE health care costs rising faster than the forecasted health care cost trends used in the original contract bids, data revisions on formal contract adjustments and routine contract changes for benefit adjustments. Specialty services revenues are recognized in the month in which the administrative services are performed or the period that coverage for services is provided.

In December 1999, the Securities and Exchange Commission issued, then subsequently amended, Staff Accounting Bulletin No. 101 ("SAB 101"), "Revenue Recognition in Financial Statements." SAB 101, as amended, provides guidance on applying accounting principles generally accepted in the United States of America to revenue recognition issues in financial statements. The Company adopted SAB 101 effective October 1, 2000. The adoption of SAB 101 did not have a material effect on the Company's consolidated financial position or results of operations.

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 which have been incurred but not yet reported. Such costs include payments to primary care physicians, specialists, hospitals, outpatient care facilities and the costs associated with managing the extent of such care. The Company estimates the amount of the provision for service costs incurred but not reported 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 amount of claims and losses paid are dependent on future developments, management is of the opinion that the recorded reserves are adequate to cover such costs. These liabilities are reduced by estimated amounts recoverable from third parties for subrogation.

The Company's HMO in California generally contracts with various medical groups to provide professional care to certain of its members on a capitated, or fixed per member per month fee basis. Capitation contracts generally include a provision for stop-loss and non-capitated services for which the Company is liable. Professional capitated contracts also generally contain provisions for shared risk, whereby the Company and the medical groups share in the variance between actual costs and predetermined goals. Additionally, the Company contracts with certain hospitals to provide hospital care to enrolled members on a capitation basis. The Company's HMOs in other states also contract with hospitals, physicians and other providers of health care, pursuant to discounted fee-for-service arrangements, hospital per diems, and case rates under which providers bill the HMOs for each individual service provided to enrollees.

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 health care related costs less reinsurance recoveries, if any, and the cost of maintaining the contracts. Losses, if any, are recognized in the period the loss is determined and are classified as Health Plan Services.

Cash and Cash Equivalents

Cash equivalents include all highly liquid investments with a maturity of three months or less when purchased.

The Company and its consolidated subsidiaries are required to set aside certain funds for restricted purposes pursuant to regulatory requirements. As of December 31, 1999, the cash and cash equivalents balance of $52.9 million was restricted and included in other noncurrent assets. There were no such restricted amounts as of December 31, 2000.

Investments

Investments classified as available for sale are reported at fair value based on quoted market prices, with unrealized gains and losses excluded from earnings and reported as other comprehensive income, net of income tax effects. The cost of investments sold is determined in accordance with the specific identification method and realized gains and losses are included in investment income.

Certain debt investments are held by trustees or agencies pursuant to state regulatory requirements. These investments totaled $7.2 million and $31.8 million as of December 31, 2000 and 1999, respectively, and are included in other noncurrent assets (see Note 11). Market values approximate carrying value at December 31, 2000 and 1999.

Government Contracts

Amounts receivable or payable under government contracts are based on three TRICARE contracts in five regions which include both amounts billed ($1.2 million and $5.1 million of net receivables at December 31, 2000 and 1999, respectively) and estimates for amounts to be received under cost and performance incentive provisions, price adjustments and change orders for services not originally specified in the contracts. Such estimates are determined based on information available as well as historical performance and collection of which could extend for periods beyond a year. Differences, which may be material, between the amounts estimated and final amounts collected are recorded in the period when determined.

In December 2000, the Company's subsidiary, Health Net Federal Services, Inc., and the Department of Defense agreed to a settlement of approximately $389 million for outstanding receivables related to the Company's three TRICARE contracts and for the completed contract for the CHAMPUS Reform Initiative. Approximately $60 million of the settlement amount was received in December 2000. The remaining settlement amount was received on January 5, 2001.

Additionally, the reserves for claims and other settlements include approximately $205.3 million and $189.7 million relating to health care services provided under these contracts as of December 31, 2000 and 1999, respectively.

Property and Equipment

Property and equipment are stated at historical cost less accumulated depreciation. Depreciation is computed using the straight-line method over the lesser of estimated useful lives of the various classes of assets or the lease term. The useful life for buildings and improvements is estimated at 35 to 40 years, and the useful lives for furniture, equipment and software range from three to eight years (see Note 5).

Effective January 1, 1999, the Company adopted Statement of Position 98-1 "Accounting for the Costs of Computer Software Developed or Obtained for Internal Use" and changed its method of accounting for the costs of internally developed computer software. The change involved capitalizing certain consulting costs, payroll and payroll related costs for employees related to computer software developed for internal use and subsequently amortizing such costs over a three to five year period. The Company had previously expensed such costs.

Expenditures for maintenance and repairs are expensed as incurred. Major improvements which increase the estimated useful life of an asset are capitalized. Upon the sale or retirement of assets, the recorded cost and the related accumulated depreciation are removed from the accounts, and any gain or loss on disposal is reflected in operations.

Goodwill and Other Intangible Assets

Goodwill and other intangible assets arise primarily as a result of various business acquisitions and consist of identifiable intangible assets acquired and the excess of the cost of the acquisitions over the tangible and intangible assets acquired and liabilities assumed (goodwill). Identifiable intangible assets consist of the value of employer group contracts, provider networks, non-compete agreements and debt issuance costs. Goodwill and other intangible assets are amortized using the straight-line method over the estimated lives of the related assets listed below. In accordance with Accounting Principles Board ("APB") Opinion No. 17, the Company periodically evaluates these estimated lives to determine if events and circumstances warrant revised periods of amortization. The Company further evaluates the carrying value of its goodwill and other intangible assets based on estimated fair value or undiscounted operating cash flows whenever significant events or changes occur which might impair recovery of recorded costs. Fully amortized goodwill and other intangible assets and the related accumulated amortization are removed from the accounts.

Impairment is measured in accordance with Statement of Financial Accounting Standards ("SFAS") No. 121 "Accounting for the Impairment of Long-Lived Assets and Long-Lived Assets to be Disposed Of" and is based on whether the asset will be held and used or held for disposal. An impairment loss on assets to be held and used is measured as the amount by which the carrying amount exceeds the fair value of the asset. Fair value of assets held for disposal would additionally be reduced by costs to sell the asset. For the purposes of analyzing impairment, assets, including goodwill, are grouped at the lowest level for which there are identifiable independent cash flows, which is generally at the operating subsidiary level. Estimates of fair value are determined using various techniques depending on the event that indicated potential impairment (see Note 15). Impairment charges for goodwill in 1999 and 1998 amounted to $4.7 million and $30.0 million, respectively (see Note 15).

Goodwill and other intangible assets consisted of the following at December 31, 2000 (amounts in thousands):

	Cost	Accumulated Amortization	Net Balance	Amortization Period
Goodwill	$ 972,707	$181,509	$791,198	9-40 years
Provider network	69,466	18,992	50,474	14-40 years
Employer group contracts	92,900	77,024	15,876	11-23 years
Other	27,002	21,131	5,871	5-7 years
Total	$1,162,075	$298,656	$863,419	

Goodwill and other intangible assets consisted of the following at December 31, 1999 (amounts in thousands):

	Cost	Accumulated Amortization	Net Balance	Amortization Period
Goodwill	$ 981,600	$157,924	$823,676	9-40 years
Provider network	69,466	15,515	53,951	14-40 years
Employer group contracts	92,900	68,874	24,026	11-23 years
Other	27,002	19,069	7,933	5-7 years
Total	$1,170,968	$261,382	$909,586	

Change in Accounting Principle

Effective January 1, 1999, the Company adopted Statement of Position 98-5 "Reporting on the Costs of Start-up Activities" and changed its method of accounting for start-up and organization costs. The change involved expensing these costs as incurred, rather than the Company's previous accounting principle of capitalizing and subsequently amortizing such costs.

The change in accounting principle resulted in the write-off of the costs capitalized as of January 1, 1999. The cumulative effect of the write-off was $5.4 million (net of tax benefit of $3.7 million) and has been expensed and reflected in the consolidated statement of operations for the year ended December 31, 1999.

Concentrations of Credit Risk

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash equivalents, investments and premiums receivable. All cash equivalents and investments are managed within established guidelines which limit the amounts which may be invested with one issuer. Concentrations of credit risk with respect to premiums receivable are limited due to the large number of payers comprising the Company's customer base. The Company's 10 largest employer groups accounted for 36% and 32% of premiums receivable and 16% and 15% of premium revenue as of December 31, 2000 and 1999, respectively, and for the years then ended.

Earnings Per Share

The Company adopted in 1997, SFAS No. 128, "Earnings Per Share." As required by SFAS No. 128, basic EPS excludes dilution and reflects income divided by the weighted average shares of common stock outstanding during the periods presented. Diluted EPS is based upon the weighted average shares of common stock and dilutive common stock equivalents (stock options) outstanding during the periods presented; no adjustment to income is required.

Common stock equivalents arising from dilutive stock options are computed using the treasury stock method; in 2000 and 1999, this amounted to 982,000 and 54,000 shares. Such shares amounting to 207,000 were antidilutive in 1998.

Options to purchase an aggregate of 4.6 million, 11.4 million, and 13.4 million shares of common stock during 2000, 1999, and 1998, respectively, were not included in the computation of diluted EPS because the options' exercise price was greater than the average market price of the common stock. These options expire through December 2010.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Principal areas requiring the use of estimates include the determination of allowances for doubtful accounts, reserves for claims and other settlements, reserves for professional and general liabilities, amounts receivable or payable under government contracts, remaining reserves for restructuring and other charges, and net realizable values for assets where impairment charges have been recorded.

Fair Value of Financial Instruments

The estimated fair value amounts of cash equivalents, investments available for sale, trade accounts and notes receivable and notes payable approximate their carrying amounts in the financial statements and have been determined by the Company 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. The fair values of investments are estimated based on quoted market prices and dealer quotes for similar investments. The fair value of notes payable is estimated based on the quoted market prices for the same or similar issues or on the current rates offered to the Company for debt with the same remaining maturities. The carrying value of long-term notes receivable approximates the fair value of such receivables. Considerable judgment is required to develop estimates of fair value. Accordingly, the estimates are not necessarily indicative of the amounts the Company could have realized in a current market exchange. The use of different market assumptions and/or estimation methodologies may have a material effect on the estimated fair value amounts.

The fair value estimates are based on pertinent information available to management as of December 31, 2000 and 1999. Although management is not aware of any factors that would significantly affect the estimated fair value amounts, such amounts have not been comprehensively revalued for purposes of these financial statements since that date, and therefore, current estimates of fair value may differ significantly.

Stock-Based Compensation

The Financial Accounting Standards Board ("FASB") issued SFAS No. 123, "Accounting for Stock-Based Compensation" ("SFAS 123"). As permitted under SFAS 123, the Company has elected to continue accounting for stock-based compensation under the intrinsic value method prescribed in APB Opinion No. 25, "Accounting for Stock Issued to Employees." Under the intrinsic value method, compensation cost for stock options is measured at the date of grant as the excess, if any, of the quoted market price of the Company's stock over the exercise price of the option (see Note 7).

In March 2000, the FASB issued Interpretation No. 44, ("Interpretation 44") "Accounting for Certain Transactions Involving Stock Compensation." Interpretation 44 provides guidance on certain implementation issues related to APB Opinion No. 25. Interpretation 44 was effective July 1, 2000 and did not have an impact on the Company's consolidated financial position or results of operations.

Comprehensive Income

Effective January 1, 1998, the Company adopted SFAS No. 130 "Reporting Comprehensive Income" ("SFAS 130"). SFAS 130 establishes standards for reporting and presenting comprehensive income and its components. Comprehensive income includes all changes in stockholders' equity (except those arising from transactions with stockholders) and includes net income and net unrealized appreciation (depreciation), after tax, on investments available for sale. Reclassification adjustments for net (losses) gains realized in net income were $(0.04) million, $0.4 million, and $2.0 million for the years ended December 31, 2000, 1999 and 1998, respectively. See Consolidated Statements of Stockholders' Equity.

Recently Issued Accounting Pronouncements

In June 1998, the FASB issued SFAS No. 133, "Accounting for Derivative Instruments and Hedging Activities" ("SFAS 133"), which is required to be adopted in fiscal years beginning after June 15, 2000. In June 1999, the FASB issued SFAS No. 137, "Accounting for Derivative Investments and Hedging Activities – Deferral of the Effective Date of FASB Statement No. 133" which delayed the adoption of SFAS 133 until January 1, 2001. The Company has completed its assessment of the impact of SFAS 133, as amended, and has concluded that the adoption of SFAS 133 will not have a material impact on its financial condition or results of operations.

Taxes Based On Premiums

The Company provides services in certain states which require premium taxes to be paid by the Company based on membership or billed premiums. These taxes are paid in lieu of or in addition to state income taxes and totaled $9.9 million in 2000, $11.7 million in 1999 and $13.9 million in 1998. These amounts are recorded in selling, general and administrative expenses on the Company's consolidated statements of operations.

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 (see Note 10).

NOTE 3 – Acquisitions and Dispositions

The following summarizes acquisitions, strategic investments, and dispositions by the Company during the three years ended December 31, 2000.

2000 Transactions

The Company sold a property in California and received cash proceeds of $3.5 million and recognized a gain of $1.1 million, before taxes.

As discussed in the "1999 Transactions," the Company completed the sale of its HMO operations in Washington. As part of the final sales true-up adjustment, the Company recorded a loss on the sale of its Washington HMO operations of $1.5 million, before taxes.

In 1995, the Company entered into a five year tax retention operating lease for the construction of various health care centers and a corporate facility. Upon expiration in May 2000, the lease was extended for four months through September 2000 whereupon the Company settled its obligations under the agreement and purchased the leased properties which were comprised of three rental health care centers and a corporate facility for $35.4 million. The health care centers are held as investment rental properties and are included in other noncurrent assets. The corporate facility building is used in operations and included in property and equipment. The buildings are being depreciated over a remaining useful life of 35 years.

Throughout 2000 and the first quarter of 2001, the Company has provided funding in the amount of approximately $4.2 million in MedUnite, Inc., an independent company, funded and organized by seven major managed health care companies. MedUnite, Inc. is designed to provide on-line internet provider connectivity services including eligibility information, referrals, authorizations, claims submission and payment. The funded amounts are included in other noncurrent assets.

During 2000, the Company secured an exclusive e-business connectivity services contract from the Connecticut State Medical Society IPA, Inc. ("CSMS-IPA") for $15.0 million. CSMS – IPA is an association of medical doctors providing health care primarily in Connecticut. The amounts paid to CSMS-IPA for this agreement are included in other noncurrent assets.

1999 Transactions

In connection with its planned divestiture of non-core operations, the Company completed the sale of certain of its non-affiliate pharmacy benefits management operations for net cash proceeds of $65.0 million and recognized a net gain of $60.6 million. In addition, the Company also completed the sale of its HMO operations in Utah, Washington, New Mexico, Louisiana, Texas and Oklahoma, as well as the sale of its two hospitals, a third-party administrator subsidiary and a PPO network subsidiary. For these businesses, the Company received an aggregate of $60.5 million in net cash proceeds, $12.2 million in notes receivable, $10.7 million in stocks and recognized a net loss of $9.1 million, before taxes. See Note 15 for impairment charges recognized during 1998 on certain of these dispositions.

In connection with the disposition of the HMO operations in Washington, the Company sold the Medicaid and Basic Health Plan membership and retained under a reinsurance and administrative agreement the commercial membership. At the same time, the Company entered into definitive agreements with PacifiCare of Washington, Inc. and Premera Blue Cross to transition the Company's commercial membership in Washington. The transition was completed as of June 30, 2000. The Company also entered into a definitive agreement with PacifiCare of Colorado, Inc. to transition the Company's HMO membership in Colorado. The transition was completed as of June 30, 2000. The dispositions do not have a material effect on the consolidated financial statements.

1998 Transactions

Call Center Operations — In December 1998, the Company sold certain of its call center operations for $36.3 million in cash, net of transaction costs, and recorded a gain of $1.2 million. In addition, the Company entered into a long-term services agreement with the buyer to provide such services to its members for a period of 10 years.

Workers' Compensation — In December 1997, the Company adopted a formal plan to sell its workers' compensation segment which was accounted for as discontinued operations. On December 10, 1998, the Company completed the sale of the workers' compensation segment. The net assets sold consisted primarily of investments, premiums and reinsurance receivables, and reserves for claims. The selling price was $257.1 million in cash.

In December 1997, the Company estimated that the loss on the disposal of the workers' compensation segment would approximate $99.0 million (net of income tax benefit of $21.0 million) which included an anticipated loss from operations during the phase-out period from December 1997 through the date of disposal. The pre-tax loss in 1998 was an additional $30.2 million. This was offset by an increase in the rate of the tax benefit of the transaction. Accordingly, the accompanying statement of operations for the year ended December 31, 1998 does not reflect any additional net gain or loss from the disposition.

NOTE 4 – Investments

As of December 31, the amortized cost, gross unrealized holding gains and losses and fair value of the Company's available-for-sale investments were as follows (amounts in thousands):

	2000			
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Carrying Value
Asset-backed securities	$108,308	$ 564	$ (149)	$108,723
U.S. government and agencies	78,953	436	(100)	79,289
Obligations of states and other political subdivisions	103,168	506	(80)	103,594
Corporate debt securities	90,525	555	(3,186)	87,894
Other securities	110,864	750	(4,212)	107,402
	$491,818	$2,811	$(7,727)	$486,902

	1999			
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Carrying Value
Asset-backed securities	$116,628	$ 5	$(1,600)	$115,033
U.S. government and agencies	98,998	13	(1,645)	97,366
Obligations of states and other political subdivisions	138,830	10	(833)	138,007
Corporate debt securities	69,602	8	(1,209)	68,401
Other securities	37,808	8	(20)	37,796
	$461,866	$44	$(5,307)	$456,603

At December 31, 2000, the contractual maturities of the Company's available-for-sale investments were as follows (amounts in thousands):

	Cost	Estimated Fair Value
Due in one year or less	$130,068	$125,770
Due after one year through five years	241,087	239,947
Due after five years through ten years	54,116	54,336
Due after ten years	66,547	66,849
Total available for sale	$491,818	$486,902

Proceeds from sales and maturities of investments available for sale during 2000 were $304.5 million, resulting in realized gains and losses of $.04 million and $.1 million, respectively. Proceeds from sales and maturities of investments available for sale during 1999 were $642.2 million, resulting in realized gains and losses of $.7 million and $.1 million, respectively. Proceeds from sales and maturities of investments available for sale during 1998 were $727.4 million, resulting in realized gains and losses of $3.6 million and $0.3 million, respectively.

NOTE 5 – Property and Equipment

Property and equipment comprised the following at December 31 (amounts in thousands):

	2000	1999
Land	$ 20,700	$ 20,645
Construction in progress	2,082	18,930
Buildings and improvements	126,702	111,936
Furniture, equipment and software	541,654	473,042
	691,138	624,553
Less accumulated depreciation	395,129	343,824
	$296,009	$280,729

NOTE 6 – Notes Payable, Capital Leases and Other Financing Arrangements

Notes payable, capital leases and other financing arrangements comprised the following at December 31 (amounts in thousands):

	2000	1999
Revolving credit facility, variable interest at LIBOR plus 1.50% at December 31, 2000, unsecured	$766,450	$1,039,250
Capital leases and other notes payable	49	1,358
Total notes payable and capital leases	766,499	1,040,608
Notes payable and capital leases — current portion	49	1,256
Notes payable and capital leases — noncurrent portion	$766,450	$1,039,352

Revolving Credit Facility

The Company established in July 1997, a $1.5 billion credit facility (the "Credit Facility") with Bank of America (as Administrative Agent for the Lenders thereto, as amended in April, July, and November 1998, March 1999, and September 2000 (the "Amendments")). All previous revolving credit facilities were terminated and rolled into the Credit Facility. At the election of the Company, and subject to customary covenants, loans are initiated on a bid or committed basis and carry interest at offshore or domestic rates, at the applicable LIBOR Rate plus margin or the bank reference rate. Actual rates on borrowings under the Credit Facility vary, based on competitive bids and the Company's unsecured credit rating at the time of the borrowing. These rates were 7.56% and 7.19% at December 31, 2000 and 1999, respectively. Under the Amendments, the Company's public issuer rating becomes the exclusive means of setting the facility fee and borrowing rates under the Credit Facility. In addition, certain covenants including financial covenants were amended. The Credit Facility is available for five years, until July 2002, but it may be extended under certain circumstances for two additional years. The weighted average annual interest rate on the Company's notes payable and capital leases was approximately 7.92%, 6.78% and 6.30% for the years ended December 31, 2000, 1999 and 1998, respectively. The maximum amount outstanding under the Credit Facility during 2000 was $1.1 billion and the maximum commitment level is $1.36 billion at December 31, 2000.

As of December 31, 2000, the Company was in compliance with the financial covenants of the Credit Facility, as amended.

Scheduled principal repayments on notes payable, capital leases and other financing arrangements are $49,000 in 2001 and $766.5 million in 2002. No principal repayments are scheduled after 2002.

NOTE 7 – Stock Option and Employee Stock Purchase Plans

The Company has various stock option plans which cover certain employees, officers and non-employee directors, and an employee stock purchase plan under which substantially all full-time employees of the Company are eligible to participate. The stockholders have approved these plans except for the 1998 Stock Option Plan which was adopted by the Company's Board of Directors.

Under the 1989, 1990, 1991, 1992, 1993, 1997 and 1998 employee stock option plans and the non-employee director stock option plan, the Company grants options at prices at or above the fair market value of the stock on the date of grant. The options carry a maximum term of up to 10 years and in general vest ratably over three to five years. The Company has reserved a total of 23.3 million shares of its Class A Common Stock for issuance under the stock option plans.

Under the Company's Employee Stock Purchase Plan, the Company provides employees with the opportunity to purchase stock through payroll deductions. Eligible employees may purchase on a monthly basis the Company's Class A Common Stock at 85% of the lower of the market price on either the first or last day of each month.

Stock option activity and weighted average exercise prices for the years ended December 31 are presented below:

	2000		1999		1998	
	Number of Options	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
Outstanding at January 1	12,284,417	$20.47	13,418,473	$20.87	9,636,831	$29.94
Granted	3,932,353	9.54	785,549	12.62	8,021,018	14.05
Exercised	(314,384)	17.73	(5,000)	14.50	(514,064)	18.64
Canceled	(3,682,604)	17.86	(1,914,605)	19.93	(3,725,312)	30.28
Outstanding at December 31	12,219,782	$17.83	12,284,417	$20.47	13,418,473	$20.87
Exercisable at December 31	4,890,364		4,824,708		4,140,362	

The following table summarizes the weighted average exercise price and weighted average remaining contractual life for significant option groups outstanding at December 31, 2000:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life (Years)	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$ 6.63 – 9.81	3,360,601	7.58	$ 9.03	40,669	$ 9.00
9.88 – 10.84	259,500	8.11	10.52	185,165	10.67
11.19 – 12.94	3,935,409	4.23	12.86	560,259	12.82
13.00 – 31.91	2,038,939	5.68	22.54	1,501,438	24.44
32.13 – 44.06	2,625,333	6.29	33.62	2,602,833	33.63
$ 6.63 – 44.06	12,219,782	5.92	$17.83	4,890,364	$27.35

The weighted average fair value for options granted during 2000, 1999 and 1998 was $5.18, $6.10 and $6.00, respectively. The fair values were estimated using the Black-Scholes option-pricing model. The following weighted average assumptions were used in the fair value calculation for 2000, 1999 and 1998, respectively: (i) risk-free interest rate of 5.97%, 6.31% and 4.57%; (ii) expected option lives of 4.2 years, 3.9 years and 4.6 years; (iii) expected volatility for both options and employee purchase rights of 63.7%, 55.7% and 44.5%; and (iv) no expected dividend yield.

The Company applies APB Opinion No. 25 and related Interpretations in accounting for its plans. Accordingly, no compensation cost has been recognized for its stock option or employee stock purchase plans. Had compensation cost for the Company's plans been determined based on the fair value at the grant dates of options and employee purchase rights consistent with the method of SFAS No. 123, the Company's net income (loss) and earnings (losses) per share would have been reduced (increased) to the pro forma amounts indicated below for the years ended December 31 (amounts in thousands, except per share data):

		2000	1999	1998
Net income (loss)	As reported	$163,623	$142,365	$(165,158)
	Pro forma	156,701	132,043	(171,022)
Basic earnings (loss) per share	As reported	1.34	1.16	(1.35)
	Pro forma	1.28	1.08	(1.40)
Diluted earnings (loss) per share	As reported	1.33	1.16	(1.35)
	Pro forma	1.27	1.08	(1.40)

On December 4, 1998, options representing approximately 1.9 million shares of stock granted during 1990 through 1997 at exercise prices ranging from $11.70 to $35.25 were exchanged for options representing approximately 1.4 million shares of stock at an exercise price of $12.94, which was the fair market value of the underlying shares on the grant date.

As fair value criteria was not applied to option grants and employee purchase rights prior to 1995, and additional awards in future years are anticipated, the effects on net income and earnings per share in this pro forma disclosure may not be indicative of future amounts.

NOTE 8 – Capital Stock

The Company has two classes of Common Stock. The Company's Class B Common Stock has the same economic benefits as the Company's Class A Common Stock but is non-voting. As of December 31, 2000 there were 122,800,000 shares of the Company's Class A Common Stock outstanding and no shares of the Company's Class B Common Stock outstanding.

Public Offering

On May 15, 1996, the Company completed a public offering in which the Company sold 3,194,374 shares of Class A Common Stock and the California Wellness Foundation ("CWF") sold 6,386,510 shares of Class A Common Stock (constituting 6,386,510 shares of Class B Common Stock which automatically converted into shares of Class A Common Stock upon the sale) for a per share purchase price to the public of $30.00 (the "Offering"). The proceeds received by the Company from the sale of the 3,194,374 shares of Class A Common Stock were approximately $92.4 million after deducting underwriting discounts and commissions and estimated expenses of the Offering payable by the Company. The Company used its net proceeds from the Offering to repurchase 3,194,374 shares of Class A Common Stock from certain Class A Stockholders. The Company repurchased these shares of Class A Common Stock from the Class A Stockholders at $30.00 per share less transaction costs associated with the Offering, amounting to $1.08 per share. All of these 3,194,374 shares of Class A Common Stock repurchased are currently held in treasury. The Company did not receive any of the proceeds from the sale of shares of Class A Common Stock in the Offering by the CWF.

On June 27, 1997, the Company redeemed 4,550,000 shares of Class B Common Stock from the CWF at a price of $24.469 per share. The Company provided its consent to permit the CWF to sell 3,000,000 shares of Class B Common Stock to an unrelated third party in June of 1997 and the CWF had the right to sell an additional 450,000 shares of Class B Common Stock to unrelated third parties, which it did throughout August of 1997. On November 6, 1997, the Company also provided its consent to permit the CWF to sell 1,000,000 shares of Class B Common Stock to unrelated third parties. In addition, on June 1, 1998, the Company gave its consent to permit the CWF to sell (and on June 18, 1998, the CWF sold) 5,250,000 shares of Class B Common Stock to unrelated third parties. In 2000 and 1999, the CWF sold 2,138,000 and 2,909,600 shares of Class B Common Stock to unrelated third parties, respectively. As a result of such sale, the CWF no longer holds any shares of Class B Common Stock. Pursuant to the Company's Certificate of Incorporation, all of such shares of Class B Common Stock sold automatically converted into shares of Class A Common Stock in the hands of such third parties.

Shareholder Rights Plan

On May 20, 1996, the Board of Directors of the Company declared a dividend distribution of one right (a "Right") for each outstanding share of the Company's Class A Common Stock and Class B Common Stock (collectively, the "Common Stock"), to stockholders of record at the close of business on July 31, 1996 (the "Record Date"). The Board of Directors of the Company also authorized the issuance of one Right for each share of Common Stock issued after the Record Date and prior to the earliest of the "Distribution Date" the Rights separate from the Common Stock under the circumstances described below and in accordance with the provisions of the Rights Agreement, as defined below, the redemption of the Rights, and the expiration of the Rights and in certain other circumstances. Rights will attach to all Common Stock certificates representing shares then outstanding and no separate Rights Certificates will be distributed. Subject to certain exceptions contained in the Rights Agreement (as amended), the Rights will separate from the Common Stock following any person, together with its affiliates and associates (an "Acquiring Person"), becoming the beneficial owner of 15% or more of the outstanding Class A Common Stock, the commencement of a tender or exchange offer that would result in any person, together with its affiliates and associates, becoming the beneficial owner of 15% or more of the outstanding Class A Common Stock or the determination by the Board of Directors that a person, together with its affiliates and associates, has become the beneficial owner of 10% or more of the Class A Common Stock and that such person is an "Adverse Person," as defined in the Rights Agreement.

The Rights will first become exercisable on the Distribution Date and will expire on July 31, 2006, unless earlier redeemed by the Company as described below. Except as set forth below and subject to adjustment as provided in the Rights Agreement, each Right entitles its registered holder, upon the occurrence of a Distribution Date, to purchase from the Company one one-thousandth of a share of Series A Junior Participating Preferred Stock, at a price of $170.00 per one-thousandth share.

Subject to certain exceptions contained in the Rights Agreement, in the event that any person shall become an Acquiring Person or be declared an Adverse Person, then the Rights will "flip-in" and entitle each holder of a Right, other than any Acquiring Person or Adverse Person, to purchase, upon exercise at the then-current exercise price of such Right, that number of shares of Class A Common Stock having a market value of two times such exercise price.

In addition and subject to certain exceptions contained in the Rights Agreement, in the event that the Company is acquired in a merger or other business combination in which the Class A Common Stock does not remain outstanding or is changed or 50% of the assets or earning power of the Company is sold or otherwise transferred to any person, the Rights will "flip-over" and entitle each holder of a Right, other than an Acquiring Person or an Adverse Person, to purchase, upon exercise at the then-current exercise price of such Right, that number of shares of common stock of the acquiring company which at the time of such transaction would have a market value of two times such exercise price.

The Company may redeem the rights until the earlier of 10 days following the date that any person becomes the beneficial owner of 15% or more of the outstanding Class A Common Stock and the date the Rights expire at a price of $.01 per Right.

In connection with the FHS Combination, the Company entered into Amendment No. 1 to the Rights Agreement to exempt the FHS Combination and related transactions from triggering the separation of the Rights. In addition, the amendment modified certain terms of the Rights Agreement applicable to the determination of certain "Adverse Persons," which modifications became effective upon consummation of the FHS Combination.

NOTE 9 – Employee Benefit Plans

Defined Contribution Retirement Plans

The Company and certain subsidiaries sponsor defined contribution retirement plans intended to qualify under Section 401(a) and 401(k) of the Internal Revenue Code of 1986, as amended (the "Code"). Participation in the plans is available to substantially all employees who meet certain eligibility requirements and elect to participate. Employees may contribute up to the maximum limits allowed by Sections 401(k) and 415 of the Code, with Company contributions based on matching or other formulas. The Company's expense under the plans totaled $8.6 million, $7.8 million and $7.4 million for the years ended December 31, 2000, 1999 and 1998, respectively.

Deferred Compensation Plans

Effective May 1, 1998, the Company adopted a deferred compensation plan pursuant to which certain management and highly compensated employees are eligible to defer between 5% and 50% of their regular compensation and between 5% and 100% of their bonuses, and non-employee Board members are eligible to defer up to 100% of their directors compensation. The compensation deferred under this plan is credited with earnings or losses measured by the mirrored rate of return on investments elected by plan participants. Each plan participant is fully vested in all deferred compensation and earnings credited to his or her account. At December 31, 2000, the employee deferrals were invested through a trust.

Prior to May 1997, certain members of management, highly compensated employees and non-employee Board members were permitted to defer payment of up to 90% of their compensation under a prior deferred compensation plan (the "Prior Plan"). The Prior Plan was frozen in May 1997 at which time each participant's account was credited with three times the 1996 Company match (or a lesser amount for certain participants) and each participant became 100% vested in all such contributions. The current provisions with respect to the form and timing of payments under the Prior Plan remain unchanged. At December 31, 2000 and 1999, the liability under these plans amounted to $21.6 million and $20.9 million, respectively. The Company's expense under these plans totaled $2.8 million, $1.9 million and $2.7 million for the years ended December 31, 2000, 1999 and 1998, respectively.

Pension and Other Postretirement Benefit Plans

Retirement Plans – The Company has two unfunded non-qualified defined benefit pension plans, a Supplemental Executive Retirement Plan (adopted in 1996) and a Directors' Retirement Plan (collectively, the "HSI SERPs"). These plans cover key executives, as selected by the Board of Directors, and non-employee directors. Benefits under the plans are based on years of service and level of compensation.

Postretirement Health and Life Plans – Certain subsidiaries of the Company sponsor postretirement defined benefit health care plans that provide postretirement medical benefits to directors, key executives, employees and dependents who meet certain eligibility requirements. Under these plans, the Company pays a percentage of the costs of medical, dental and vision benefits during retirement. The plans include certain cost-sharing features such as deductibles, co-insurance and maximum annual benefit amounts which vary based principally on years of credited service.

On December 31, 1998, the Company adopted SFAS No. 132 "Employers' Disclosures about Pension and Other Postretirement Benefits" ("SFAS No. 132"), which revises employers' disclosures about pension and other postretirement benefit plans. SFAS No. 132 standardizes the disclosure requirements. The Company has chosen to disclose the information required by SFAS No. 132 by aggregating retirement plans into the "Pension Benefits" category and postretirement plans into the "Other Benefits" category.

The following table sets forth the plans' funded status and amounts recognized in the Company's financial statements (amounts in thousands):

	Pension Benefits		Other Benefits	
	2000	1999	2000	1999
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 12,287	$ 15,103	$ 5,506	$ 4,060
Service cost	1,174	1,762	595	603
Interest cost	972	989	388	324
Benefits paid	(967)	(1,112)	(95)	(94)
Actuarial loss (gain)	708	(4,455)	52	613
Projected benefit obligation, end of year	$ 14,174	$ 12,287	$ 6,446	$ 5,506
Change in fair value of plan assets:				
Plan assets, beginning of year	$ –	$ –	$ –	$ –
Employer contribution	967	1,112	24	21
Benefits paid	(967)	(1,112)	(24)	(21)
Plan assets, end of year	$ –	$ –	$ –	$ –
Funded status of plans	$(14,174)	$(12,287)	$(6,446)	$(5,506)
Unrecognized prior service cost	4,499	4,969	(204)	(211)
Unrecognized (gain)	(2,465)	(3,338)	(1,511)	(1,645)
Net amount recognized as accrued benefit liability	$(12,140)	$(10,656)	$(8,161)	$(7,362)

The components of net periodic benefit costs for the years ended December 31, 2000, 1999 and 1998 are as follows (amounts in thousands):

	Pension Benefits			Other Benefits		
	2000	1999	1998	2000	1999	1998
Service cost	$1,174	$1,762	$1,525	$595	$603	$ 356
Interest cost	972	989	756	388	324	252
Amortization of prior service cost	469	474	308	(6)	(6)	(8)
Amortization of unrecognized (gain) loss	(165)	103	72	(82)	(58)	(115)
	2,450	3,328	2,661	895	863	485
Cost of subsidiary plan curtailment	–	–	1,896	–	–	(13)
Net periodic benefit cost	$2,450	$3,328	$4,557	$895	$863	$ 472

The weighted average annual discount rate assumed was 7.50% and 7.75% for the years ended December 31, 2000 and 1999, respectively, for both pension plan benefit plans and other postretirement benefit plans. Weighted average compensation increases of between 2.00% to 6.00% for the years ended December 31, 2000 and 1999 were assumed for the pension benefit plans.

For measurement purposes, depending upon the type of coverage offered, a 6.00% to 9.00% annual rate of increase in the per capita cost covered health care benefits was assumed for 2000, and 6.00% was assumed for 1999. These rates were assumed to decrease gradually to between 5.50% and 6.00% in 2007 for 2000 and to 4.50% in 2006 for 1999.

The Company has multiple postretirement medical benefit plans. The Health Net plan is non-contributory for employees retired prior to December 1, 1995 who have attained the age of 62; employees retiring after December 1, 1995 who have attained age 62 contribute from 25% to 100% of the cost of coverage depending upon years of service. The Company has two other benefit plans that it has acquired as part of the acquisitions made in 1997. One of the plans is frozen and non-contributory, whereas the other plan is contributory by certain participants.

A one percentage point change in assumed health care cost trend rates would have the following effects for the year ended December 31, 2000 (amounts in thousands):

	1-percentage point increase	1-percentage point decrease
Effect on total of service and interest cost	$ 258	$ (190)
Effect on postretirement benefit obligation	1,333	(1,017)

The Company has no minimum pension liability adjustment to be included in comprehensive income.

Performance-Based Annual Bonus Plan

In 2000, the Company adopted a new Executive Officer Incentive Plan that qualifies as a Performance-Based Annual Bonus Plan under Section 162(m) of the Code (the "162(m) Plan"). Under the 162(m) Plan, certain executives were eligible to receive cash bonuses based upon the attainment of objective performance goals established by the Company's Compensation and Stock Option Committee pursuant to the terms of the 162(m) Plan.

NOTE 10 – Income Taxes

Significant components of the provision (benefit) for income taxes are as follows for the years ended December 31 (amounts in thousands):

	2000	1999	1998
Current:			
Federal	$18,459	$29,080	$ 6,346
State	10,349	(6,448)	3,897
Total current	28,808	22,632	10,243
Deferred:			
Federal	64,644	52,419	(121,800)
State	5,672	21,175	(7,630)
Total deferred	70,316	73,594	(129,430)
Total provision (benefit) for income taxes	$99,124	$96,226	$(119,187)

The $119.2 million tax benefit in 1998 includes $30,191,000 of tax benefit associated with the disposition of the Company's workers' compensation segment, which was recorded as a discontinued operation in 1997. The tax benefit offsets additional pretax losses recorded upon completion of the sale in December 1998.

A reconciliation of the statutory federal income tax rate and the effective income tax rate on income from continuing operations is as follows for the years ended December 31:

	2000	1999	1998
Statutory federal income tax rate	35.0%	35.0%	(35.0)%
State and local taxes, net of federal income tax effect	4.0	3.9	(1.5)
Tax exempt interest income	(0.9)	(1.1)	(1.3)
Goodwill amortization	3.3	3.4	5.7
Examination settlements	(2.3)	(1.9)	–
Merger transaction costs	–	–	(3.2)
Other, net	(1.4)	0.1	0.3
Effective income tax rate	37.7%	39.4%	(35.0)%

Significant components of the Company's deferred tax assets and liabilities as of December 31 are as follows (amounts in thousands):

	2000	1999
DEFERRED TAX ASSETS:		
Accrued liabilities	$ 28,570	$ 52,491
Insurance loss reserves and unearned premiums	4,627	6,144
Tax credit carryforwards	12,709	8,059
Accrued compensation and benefits	33,089	33,838
Restructuring reserves	–	4,025
Net operating loss carryforwards	115,462	165,023
Other	8,687	16,363
Deferred tax assets before valuation allowance	203,144	285,943
Valuation allowance	(16,813)	(47,092)
Net deferred tax assets	$186,331	$238,851
DEFERRED TAX LIABILITIES:		
Depreciable and amortizable property	$ 53,214	$ 35,388
Other	–	50
Deferred tax liabilities	$ 53,214	$ 35,438

In 2000 and 1998, income tax benefits attributable to employee stock option transactions of $0.5 million and $6.3 million, respectively, were allocated to stockholders' equity. No income tax benefits were allocated to stockholders' equity during 1999.

As of December 31, 2000, the Company had federal and state net operating loss carryforwards of approximately $296.7 million and $232.5 million, respectively. The net operating loss carryforwards expire between 2001 and 2019. Limitations on utilization may apply to approximately $36.9 million and $80.7 million of the federal and state net operating loss carryforwards, respectively. Accordingly, valuation allowances have been provided to account for the potential limitations on utilization of these tax benefits. During the year ended December 31, 2000, the valuation allowance decreased by $30.3 million resulting from changes in realizability of an acquired subsidiary's deferred tax assets. The tax benefit reduced associated goodwill. Of the remaining valuation allowance, $14.9 million will also be allocated to goodwill in the event certain deferred tax assets are realized.

NOTE 11 – Regulatory Requirements

All of the Company's health plans as well as its insurance subsidiaries are required to periodically file financial statements with regulatory agencies in accordance with statutory accounting and reporting practices. Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended, California plans must comply with certain minimum capital or tangible net equity requirements. The Company's non-California health plans, as well as its health and life insurance companies, must comply with their respective state's minimum regulatory capital requirements and in certain cases, maintain minimum investment amounts for the restricted use of the regulators which as of December 31, 2000 totaled $7.2 million. Also, under certain government regulations, certain subsidiaries are required to maintain a current ratio of 1:1 and to meet other financial standards.

As a result of the above requirements and other regulatory requirements, certain subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to the Company. Such restrictions, unless amended or waived, limit the use of any cash generated by these subsidiaries to pay obligations of the Company. The maximum amount of dividends which can be paid by the insurance company subsidiaries to the Company without prior approval of the insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. Management believes that as of December 31, 2000, all of the Company's health plans and insurance subsidiaries met their respective regulatory requirements.

NOTE 12 – Commitments and Contingencies

Legal Proceedings

The Company and its former wholly-owned subsidiary, Foundation Health Corporation ("FHC"), were named in an adversary proceeding, Superior National Insurance Group, Inc. v. Foundation Health Corporation, Foundation Health Systems, Inc. and Milliman & Robertson, Inc. ("M&R"), filed on April 28, 2000, in the United States Bankruptcy Court for the Central District of California. The lawsuit relates to the 1998 sale of Business Insurance Group, Inc., a holding company of workers' compensation companies operating primarily in

California ("BIG"), by FHC to Superior National Insurance Group, Inc. ("Superior"). On March 3, 2000, the California Department of Insurance seized BIG and Superior's other California insurance subsidiaries. On April 26, 2000, Superior filed for Bankruptcy. Two days later, Superior filed its lawsuit against the Company, FHC and M&R. Superior alleges that the BIG transaction was a fraudulent transfer under federal and California bankruptcy laws in that Superior did not receive reasonably equivalent value for the $285 million in consideration paid for BIG; that the Company, FHC and M&R defrauded Superior by making misstatements as to the adequacy of BIG's reserves; that Superior is entitled to rescind its purchase of BIG; that Superior is entitled to indemnification for losses it allegedly incurred in connection with the BIG transaction; that FHC breached the Stock Purchase Agreement; and that FHC and the Company were guilty of California securities laws violations in connection with the sale of BIG. Superior seeks $300 million in compensatory damages, unspecified punitive damages and the costs of the action, including attorneys' fees. On August 1, 2000, a motion filed by the Company and FHC to remove the lawsuit from the jurisdiction of the Bankruptcy Court to the United States District Court for the Central District of California was granted, and the lawsuit is now pending in the District Court. The parties are currently engaged in discovery. On January 1, 2001, FHC was merged into the Company. The Company intends to defend itself vigorously in this litigation.

Since May 1998, several complaints (the "FPA Complaints") have been filed in federal and state courts seeking an unspecified amount of damages on behalf of an alleged class of persons who purchased shares of common stock, convertible subordinated debentures and options to purchase common stock of FPA Medical Management, Inc. ("FPA") at various times between February 3, 1997 and May 15, 1998. The FPA Complaints name as defendants FPA, certain of FPA's auditors, the Company and certain of the Company's former officers. The FPA Complaints allege that the Company and such former officers violated federal and state securities laws by misrepresenting and failing to disclose certain information about a 1996 transaction between the Company and FPA, about FPA's business and about the Company's 1997 sale of FPA common stock held by the Company. All claims against the Company's former officers were voluntarily dismissed from the consolidated class actions in both federal and state court. The Company has filed a motion to dismiss all claims asserted against it in the consolidated federal class actions but has not formally responded to the other complaints. The Company intends to vigorously defend the actions.

In September 1983, a lawsuit was filed in Los Angeles Superior Court by Baja Inc. ("Baja") against East Los Angeles Doctors Hospital Foundation, Inc. ("Hospital") and Century Medicorp ("Century") arising out of a multi-phase written contract for operation of a pharmacy at the Hospital during the period September 1978 through September 1983. In October 1992, Foundation Health Corporation, which became a subsidiary of the Company, acquired the Hospital and Century, and thereafter continued the vigorous defense of this action. In August 1993, the Court awarded Baja $549,532 on a portion of its claim. In December 1994, the Court concluded that Baja also could seek certain additional damages subject to proof. On July 5, 1995, the Court awarded Baja an additional $1,015,173 (plus interest) in lost profits damages. In October 1995, both of the parties appealed. The Court of Appeal reversed portions of the judgment, directing the trial court to conduct additional hearings on Baja's damages. In January 2000, after further proceedings on the issue of Baja's lost profits, the Court awarded Baja $4,996,019 in addition to the previous amounts, plus prejudgment interest. The Company has satisfied substantially all of the judgment with the exception of the amounts related to the interest awarded on the judgment, which the Company is appealing.

On November 22, 1999, a complaint was filed in the United States District Court for the Southern District of Mississippi in a lawsuit entitled Pay v. Foundation Health Systems, Inc. The complaint seeks certification of a nationwide class action and alleges that cost containment measures used by the Company's health maintenance organizations, preferred provider organizations and point-of-service health plans violate provisions of the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") and the federal Employee Retirement Income Security Act ("ERISA"). The action seeks unspecified damages and injunctive relief. The case was stayed on January 25, 2000, pending the resolution of various procedural issues involving similar actions filed against Humana, Inc. On June 23, 2000, the plaintiffs filed amended complaints in a Humana action that had been consolidated pursuant to the multi-district litigation statute in the Southern District of Florida to add claims against other managed care organizations, including the Company. On October 23, 2000, the court allowed the plaintiffs to further amend the complaint against the Company to add two new named plaintiffs and withdraw the originally named plaintiff, Kerrie Pay, from the action. Consequently, this case is now entitled *Romero v. Foundation Health Systems, Inc.* On October 23, 2000, the Judicial Panel on Multi-District Litigation ruled that the action originally filed against the Company in the Southern District of Mississippi should be consolidated, for purposes of pre-trial proceedings only, with other cases pending against managed care organizations in the

United States District Court for the Southern District of Florida in Miami. The Company has filed a motion to dismiss the case. Briefing on the motion to dismiss has been completed and the matter is currently pending before the court. Preliminary discovery and briefing regarding the plaintiff's motion for class certification has also been completed and the matter is also pending before the court. The Company intends to vigorously defend the action.

On August 17, 2000, a complaint was filed in the United States District Court for the Southern District of Florida in a lawsuit entitled Shane v. Humana, Inc., et al. (including Foundation Health Systems, Inc.). The complaint seeks certification of a nationwide class action on behalf of physicians and alleges that the defendant managed care companies' methods of reimbursing physicians violate provisions of RICO, ERISA, certain federal regulations and various state laws. The action seeks unspecified damages and injunctive relief. On September 22, 2000, the Company filed a motion to dismiss, or in the alternative to compel arbitration. On December 11, 2000, the court granted in part and denied in part the Company's motion to compel arbitration. Under the court's order, the single named plaintiff to allege a direct contractual relationship with the Company is compelled to arbitrate his direct claims against the Company. The Company intends to vigorously defend the action.

Physicians Health Services, Inc. ("PHS"), a subsidiary of the Company, was sued on December 14, 1999 in the United States District Court in Connecticut by the Attorney General of Connecticut, Richard Blumenthal, acting on behalf of a group of state residents. The lawsuit was premised on ERISA, and alleged that PHS violated its duties under that Act by managing its prescription drug formulary in a manner that served its own financial interest rather than those of plan beneficiaries. The suit sought to have PHS revamp its formulary system, and to provide patients with written denial notices and instructions on how to appeal. PHS filed a motion to dismiss which asserted that the state residents the Attorney General purported to represent all received a prescription drug appropriate for their conditions and therefore suffered no injuries whatsoever, that his office lacked standing to bring the suit and that the allegations failed to state a claim under ERISA. On July 12, 2000, the court granted PHS' motion and dismissed the action. The State of Connecticut has filed an appeal.

Meanwhile, on September 7, 2000, the Attorney General of Connecticut, Richard Blumenthal, filed another lawsuit against Physicians Health Services of Connecticut, Inc. ("PHS-CT"). This new suit also names Foundation Health Systems, Inc., Anthem Blue Cross and Blue Shield of CT, Anthem Health Plans, Inc., CIGNA Healthcare of CT, Inc., and Oxford Health Plans of CT, Inc. as defendants, and asserts claims against PHS-CT and the Company that are similar, if not identical, to those asserted in the previous lawsuit that was dismissed on July 12, 2000. On November 30, 2000, the clerk of the Judicial Panel on Multi-District Litigation entered an order conditionally transferring this case to the United States District Court for the Southern District of Florida to be consolidated for pretrial proceedings only with the other cases against managed care organizations pending in that court. The clerk of the Judicial Panel on Multi-District Litigation stayed the conditional transfer order on December 15, 2000 pending briefing and argument concerning whether transfer is appropriate. The Connecticut District Court has stayed the case pending the outcome of the Judicial Panel on Multi-District Litigation proceedings. The Company intends to vigorously defend the action.

On September 7, 2000, a complaint was filed in the United States District Court for the District of Connecticut in a lawsuit entitled Albert v. CIGNA Healthcare of Connecticut, Inc., et al. (including Physicians Health Services of Connecticut, Inc. and Foundation Health Systems, Inc.). The complaint seeks certification of a nationwide class action and alleges that the defendant managed care companies' various practices violate provisions of ERISA. The action seeks unspecified damages and injunctive relief. On November 30, 2000, the clerk of the Judicial Panel on Multi-District Litigation entered an order conditionally transferring this case to the United States District Court for the Southern District of Florida to be consolidated for pretrial proceedings only with the other cases against managed care organizations pending in that court. The clerk of the Judicial Panel on Multi-District Litigation stayed the conditional transfer order on December 15, 2000 pending briefing and argument concerning whether transfer is appropriate. The plaintiff is objecting to transfer. The Company intends to vigorously defend the action.

In May 2000, the California Medical Association filed a lawsuit, purportedly on behalf of its member physicians, in the United States District Court for the Northern District of California against several managed care organizations, including the Company, entitled California Medical Association v. Blue Cross of California, Inc., PacifiCare Health Systems, Inc.,

PacifiCare Operations, Inc. and Foundation Health Systems, Inc. The plaintiff alleges that the manner in which the defendants contract and interact with its member physicians violates provisions of RICO. The action seeks declaratory and injunctive relief, as well as costs and attorneys fees. The Company filed a motion to dismiss the action on various grounds. In August 2000, plaintiffs in other actions pending against different managed care organizations petitioned the Judicial Panel on Multi-District Litigation to consolidate the California action with the other actions in the U.S. District Court for the Northern District of Alabama. In light of the pending petition, the California court stayed the action and the hearing on the Company's motion to dismiss the complaint for ninety days pending a determination of the petition to consolidate. On October 23, 2000, the Judicial Panel on Multi-District Litigation ruled that this case should be consolidated, for purposes of pre-trial proceedings only, with other cases pending against managed care organizations in the United States District Court for the Southern District of Florida in Miami. The Company intends to vigorously defend the action.

The Company and certain of its subsidiaries are also parties to various other legal proceedings, many of which involve claims for coverage encountered in the ordinary course of its business. Based in part on advice from litigation counsel to the Company and upon information presently available, management of the Company is of the opinion that the final outcome of all such proceedings should not have a material adverse effect upon the Company's results of operations or financial condition.

Operating Leases

The Company leases administrative office space under various operating leases. Certain leases contain renewal options and rent escalation clauses.

On September 30, 2000, Health Net of California, Inc. entered into an operating lease agreement to lease office space in Woodland Hills, California for substantially all of its operations once its current office lease expires. The new lease is anticipated to commence on January 1, 2002 for a term of 10 years. The total future minimum lease commitments under the lease are approximately $96.7 million.

Future minimum lease commitments for noncancelable operating leases at December 31, 2000 are as follows (amounts in thousands):

2001	$ 47,126
2002	40,764
2003	29,183
2004	22,915
2005	16,199
Thereafter	82,153
Total minimum lease commitments	$238,340

Rent expense totaled $49.8 million, $49.0 million and $50.3 million in 2000, 1999 and 1998, respectively.

NOTE 13 – Related Parties

One current director of the Company was a partner in a law firm which received legal fees totaling $0.3 million, $1.2 million, and $1.0 million, in 2000, 1999, and 1998, respectively. Such law firm is also an employer group of the Company from which the Company receives premium revenues at standard rates. One current director was an officer of IBM which the Company paid $16.7 million, $9.0 million and $8.0 million for products and services in 2000, 1999 and 1998, respectively, and one current director is also a director of a temporary staffing company which the Company paid $1.9 million, $11.0 million and $20.4 million in 2000, 1999 and 1998, respectively.

A director of the Company was paid $70,000, and $25,000 in consulting fees in 2000 and 1999, respectively, due to various services provided to the Company in connection with the closing of its operations in Pueblo, Colorado (see Note 15). In addition, two of this director's law firm partners purchased a building from the Company in Pueblo, Colorado, for $405,000 in 1999.

During 1998, three executive officers of the Company, in connection with their hire or relocation,

received one-time loans from the Company aggregating $775,000 which ranged from $125,000 to $400,000 each. The loans accrue interest at the prime rate and each is payable upon demand by the Company in the event of a voluntary termination of employment of the respective officer or termination for cause. During 1999, three executive officers of the Company, in connection with their hire or relocation, received one-time loans from the Company aggregating $550,000 which ranged from $100,000 to $300,000 each. The loans accrue interest at the prime rate and each is payable upon demand by the Company in the event of a voluntary termination of employment of the respective officer or termination for cause.

The principal and interest of the loans will be forgiven by the Company at varying times between one and five years after the date of hire or relocation of the respective officers. As of December 31, 2000, the aggregate outstanding principal balance of the six loans was $648,334.

NOTE 14 – Asset Impairment, Merger, Restructuring and Other Costs

The following sets forth the principal components of asset impairment, merger, restructuring and other costs for the years ended December 31 (amounts in millions):

	2000	1999	1998
Severance and benefit related costs	$ –	$17.2	$ 21.2
Real estate lease termination costs	–	0.8	–
Asset impairments and other charges related to FPA Medical Management	–	–	84.1
Asset impairment and other costs	–	6.2	112.4
Other costs	–	1.7	22.4
	–	25.9	240.1
Modifications to prior year restructuring plans	–	(14.2)	–
Total	$ –	$11.7	$240.1

1999 Charges

The following tables summarize the 1999 charges by quarter and by type (amounts in millions):

				1999 Activity		
	1999 Charges	1999 Modifications to Estimate	Net 1999 Charges	Cash Payments	Non-Cash	Balance at December 31, 1999
Severance and benefit related costs	$18.5	$(1.3)	$17.2	$ (8.6)	$ –	$8.6
Asset impairment costs	6.2	–	6.2	–	(6.2)	–
Real estate lease termination costs	0.8	–	0.8	(0.8)	–	–
Other costs	1.8	(0.1)	1.7	(1.4)	–	0.3
Total	$27.3	$(1.4)	$25.9	$(10.8)	$(6.2)	$8.9
First Quarter 1999 Charge	$21.1	$(1.4)	$19.7	$(10.8)	$ –	$8.9
Fourth Quarter 1999 Charge	6.2	–	6.2	–	(6.2)	–
Total	$27.3	$(1.4)	$25.9	$(10.8)	$(6.2)	$8.9

	Balance at December 31, 1999	2000 Cash Payments	Balance at December 31, 2000	Expected Future Cash Outlays
Severance and benefit related costs	$8.6	$(8.6)	$ –	$ –
Asset impairment costs	–	–	–	–
Real estate lease termination costs	–	–	–	–
Other costs	0.3	(0.3)	–	–
Total	$8.9	$(8.9)	$ –	$ –
First Quarter 1999 Charge	$8.9	$(8.9)	$ –	$ –
Fourth Quarter 1999 Charge	–	–	–	–
Total	$8.9	$(8.9)	$ –	$ –

During the fourth quarter of 1998, the Company initiated a formal plan to dispose of certain health plans of the Company's then Central Division included in the Company's Health Plan Services segment in accordance with its anticipated divestitures program. In this connection, the Company announced in 1999 its plan to close the Colorado regional processing center, terminate employees and transfer its operations to the Company's other administrative facilities. In addition, the Company also announced its plans to consolidate certain administrative functions in its Oregon and Washington health plan operations. During the year ended December 31, 1999, the Company recorded pretax charges for restructuring and other charges of $21.1 million (the "1999 Charges") and $6.2 million, respectively.

Severance and Benefit Related Costs – The 1999 Charges included $18.5 million for severance and benefit costs related to executives and operations employees at the Colorado regional processing center and operations employees at the Northwest health plans. The operations functions include premium accounting, claims, medical management, customer service, sales and other related departments. The 1999 Charges included the termination of a total of 773 employees. As of December 31, 2000, termination of the employees was completed and $17.2 million had been paid. There are no expected future cash outlays. Modifications to the initial estimate of $1.3 million were recorded during the year ended December 31, 1999.

Asset Impairment Costs – During the fourth quarter ended December 31, 1999, the Company recorded asset impairment costs totaling $6.2 million related to impairment of certain long-lived assets held for disposal (see Note 15).

Real Estate Lease Termination and Other Costs – The 1999 Charges included $2.6 million related to termination of real estate obligations and other costs to close the Colorado regional processing center.

The 1999 restructuring plan was completed as of December 31, 2000.

1998 Charges

The following tables summarize the 1998 charges by quarter and by type (amounts in millions):

	Activity during 1998 and 1999					2000 Activity		
	1998 Charges	Cash Payments	Non-Cash	1999 Modification to Estimate	Balance at Dec. 31, 1999	Cash Payments	Balance at Dec. 31, 2000	Expected Future Cash Outlays
Severance and benefit related costs	$ 21.2	$ (18.2)	$ (1.9)	$ (1.0)	$ 0.1	$ (0.1)	$ –	$ –
Asset impairment and other charges related to FPA	84.1	(16.6)	(66.9)	(0.6)	–	–	–	–
Asset impairment and other	112.4	(0.8)	(100.9)	(10.7)	–	–	–	–
Other costs	22.4	(3.5)	(18.6)	(0.3)	–	–	–	–
Total	$ 240.1	$ (39.1)	$ (188.3)	$ (12.6)	$ 0.1	$ (0.1)	$ –	$ –
Second Quarter 1998 Charge	$ 50.0	$ (8.9)	$ (41.1)	$ -	$ –	$ –	$ –	$ –
Third Quarter 1998 Charge	71.7	(23.7)	(46.0)	(1.9)	0.1	(0.1)	–	–
Fourth Quarter 1998 Charge	118.4	(6.5)	(101.2)	(10.7)	–	–	–	–
Total	$ 240.1	$ (39.1)	$ (188.3)	$ (12.6)	$ 0.1	$ (0.1)	$ –	$ –

Severance and Benefit Related Costs – During the year ended December 31, 1998, the Company recorded severance costs of $21.2 million related to staff reductions in selected health plans and the corporate centralization and consolidation. This plan included the termination of 683 employees in seven geographic locations primarily relating to corporate finance and human resources functions and California operations. As of December 31, 1999, the termination of employees had been completed and $20.1 million had been recorded as severance under this plan.

FPA Medical Management – On July 19, 1998, FPA Medical Management, Inc. ("FPA") filed for bankruptcy protection under Chapter 11 of the Federal Bankruptcy Code. FPA, through its affiliated medical groups, provided services to approximately 190,000 of the Company's affiliated members in Arizona and California and also leased health care facilities from the Company. FPA has discontinued its medical group operations in these markets and the Company has made other arrangements for health care services to the Company's affiliated members. The FPA bankruptcy and related events and circumstances caused management to re-evaluate the decision to continue to operate the facilities and management determined to sell the 14 properties, subject to bankruptcy court approval. Management immediately commenced the sale process upon such determination. The estimated fair value of the assets held for disposal was determined based on the estimated sales prices less the related costs to sell the assets. Management believed that the net proceeds from a sale of the facilities would be inadequate to enable the Company to recover their carrying value. Based on management's best estimate of the net realizable values, the Company recorded charges totaling approximately $84.1 million. These charges were comprised of $63.0 million for real estate asset impairments, $10.0 million impairment adjustment of a note received as consideration in connection with the 1996 sale of the Company's physician practice management business and $11.1 million for other items. These other items included payments made to Arizona physician specialists totaling $3.4 million for certain obligations that FPA had assumed but was unable to pay due to its bankruptcy, advances to FPA to fund certain operating expenses totaling $3.0 million, and other various costs totaling $4.7 million. The carrying value of the assets held for disposal totaled $9.9 million at December 31, 2000. There have been no further adjustments to the carrying value of these assets held for disposal. As of December 31, 2000, 12 properties have been sold which has resulted in net gains of $5.0 million during 1999 and $3.6 million in 1998 which are included in net gains on sale of businesses and buildings. The remaining properties are expected to be sold during 2001. The effects of the suspension of real estate depreciation on the respective properties had an impact of approximately $2.0 million in 1998 and were immaterial during 2000 and 1999. The results of operations attributable to FPA real estate assets were immaterial during 1998, 1999 and 2000.

Asset Impairment and Other Charges – During the fourth quarter ended December 31, 1998, the Company recorded impairment and other charges totaling $118.4 million. Of this amount, $112.4 million related to impairment of certain long-lived assets held for disposal (see Note 15) and $6 million related to the FPA bankruptcy.

Other Costs – The Company recorded other costs of $22.4 million which included the adjustment of amounts due from a third-party hospital system that filed for bankruptcy which were not related to the normal business of the Company totaling $18.6 million, and $3.8 million related to other items such as fees for consulting services from one of the Company's prior executives and costs related to exiting certain rural Medicare markets.

During 1999, modifications of $12.6 million to the initial estimates were recorded. These credits to the 1998 charges included: $10.7 million from reductions to asset impairment costs and $1.9 million from reductions to initially anticipated involuntary severance costs and other adjustments.

NOTE 15 – Impairment of Long-Lived Assets

During 1998, the Company initiated a formal plan to dispose of certain Central Division health plans included in the Company's Health Plan Services segment in accordance with its previously disclosed anticipated divestitures program. Pursuant to SFAS No. 121, the Company evaluated the carrying values of the assets for these health plans and the related service center and holding company, and determined that the carrying value of these assets exceeded the estimated fair values of these assets. Estimated fair value is determined by the Company based on the current stages of sales negotiation, including letters of intent, definitive agreements, and sales discussions, net of expected transaction costs.

In the case of the Colorado regional processing center and holding company operations, buildings, furniture, fixtures, equipment and software development projects were determined by management to have no continuing value to the Company, due to the Company abandoning plans for the development of this location and its systems and programs as a centralized operations center.

Accordingly, in the fourth quarter of 1998, the Company adjusted the carrying value of these long-lived assets to their estimated fair value, resulting in a non-cash asset impairment charge of approximately $112.4 million (see Note 14). This asset impairment charge of $112.4 million consists of $40.3 million for write-downs of abandoned furniture, equipment and software development projects; $20.9 million write-down of buildings and improvements; $30.0 million for write-down of goodwill; and $21.2 million for other impairments and other charges. The fair value is based on expected net realizable value. Revenue and pretax loss were $7.7 million and $0.4 million for the year ended December 31, 2000. Revenue and pretax income attributed to these Central Division plans were $191.3 million and $9.8 million for the year ended December 31, 1999, and revenue and pretax loss were $346.8 million and $36.1 million for the year ended December 31, 1998. The carrying value of these assets as of December 31, 2000, 1999, and 1998 was $3.9 million, $22.1 million, and $42.8 million, respectively. No subsequent adjustments were made to these assets in 1998, 1999 and 2000.

During the fourth quarter of 1999, the Company recorded asset impairment costs totaling $6.2 million in

connection with pending dispositions of non-core businesses. These charges included a $4.7 million reduction in the carrying value of the Company's Pittsburgh health plans to fair value. The Company also adjusted the carrying value of its subacute operations by $1.5 million to fair value. The revenue and pretax income attributable to these operations were $59.7 million and $1.3 million for the year ended December 31, 2000. Revenue and pretax losses attributable to these operations were $66.2 million and $1.4 million for the year ended December 31, 1999. The carrying value of these assets as of December 31, 2000, and 1999 was $14.5 million and $16.2 million, respectively.

NOTE 16 – Segment Information

As of December 31, 1998, the Company adopted SFAS No. 131, "Disclosures About Segments of an Enterprise and Related Information" ("SFAS 131"). SFAS 131 establishes annual and interim reporting standards for an enterprise's reportable segments and related disclosures about its products, services, geographic areas and major customers. Under SFAS 131, reportable segments are to be defined on a basis consistent with reports used by management to assess performance and allocate resources. The Company's reportable segments are business units that offer different products to different classes of customers. The Company has two reportable segments: Health Plan Services and Government Contracts/Specialty Services. The Health Plan Services segment provides a comprehensive range of health care services through HMO and PPO networks. The Government Contracts/Specialty Services segment administers large, multi-year managed care government contracts and also offers behavioral, dental, vision, and pharmaceutical products and services.

The Company evaluates performance and allocates resources based on profit or loss from operations before income taxes. The accounting policies of the reportable segments are the same as those described in the summary of significant accounting policies, except intersegment transactions are not eliminated.

Presented below are segment data for the three years in the period ended December 31 (amounts in thousands):

2000	Health Plan	Government Contracts/ Specialty Services	Corporate and Other(i)	Total
Revenues from external sources	$7,351,098	$1,623,158	$ –	$8,974,256
Intersegment revenues	–	67,325	–	67,325
Investment and other income	90,144	11,237	918	102,299
Interest expense	2,796	24	85,110	87,930
Depreciation and amortization	58,711	15,012	32,176	105,899
Segment profit (loss)	297,323	111,147	(145,723)	262,747
Segment assets	2,815,506	805,609	49,001	3,670,116

1999	Health Plan	Government Contracts/ Specialty Services	Corporate and Other(i)	Total
Revenues from external sources	$7,031,055	$1,529,855	$ –	$8,560,910
Intersegment revenues	–	78,083	–	78,083
Investment and other income	81,761	7,820	(2,604)	86,977
Interest expense	5,624	102	78,082	83,808
Depreciation and amortization	71,409	14,736	25,896	112,041
Segment profit (loss)	218,318	118,455	(92,765)	244,008
Segment assets	2,596,285	796,362	303,834	3,696,481

1998 (ii)	Health Plan	Government Contracts/ Specialty Services	Corporate and Other(i)	Total
Revenues from external sources	$7,124,161	$1,411,267	$ –	$8,535,428
Intersegment revenues	–	63,008	–	63,008
Investment and other income	76,455	19,500	(2,514)	93,441
Interest expense	11,905	314	79,940	92,159
Depreciation and amortization	89,008	13,891	25,194	128,093
Segment profit (loss)	(101,959)	123,385	(275,580)	(254,154)
Segment assets	2,780,783	800,767	281,719	3,863,269

(i) *Includes intersegment eliminations.*

(ii) *Excludes workers' compensation segment treated as discontinued operations which was sold in 1998. See Note 3.*

NOTE 17 – Quarterly Information (Unaudited)

The following interim financial information presents the 2000 and 1999 results of operations on a quarterly basis (in thousands, except per share data). Certain 1999 revenue amounts have been reclassified to conform to the 2000 presentation:

	March 31	June 30	September 30	December 31
2000:				
Total revenues	$2,199,335	$2,229,600	$2,287,815	$2,359,805
Income from continuing operations before income taxes	55,262	62,796	70,444	74,245
Net income	34,055	38,695	44,647	46,226
BASIC EARNINGS PER SHARE [1]				
Net income	0.28	0.32	0.36	0.38
DILUTED EARNINGS PER SHARE [1]				
Net income	0.28	0.32	0.36	0.37

	March 31	June 30	September 30	December 31
1999:				
Total revenues	$2,158,344	$2,128,989	$2,156,920	$2,203,634
Income from continuing operations before income taxes	78,779	46,549	58,341	60,339
Income before cumulative effect of a change in accounting principle, net of tax	47,338	27,969	35,089	37,386
Net income	41,921	27,969	35,089	37,386
BASIC AND DILUTED EARNINGS PER SHARE [1]				
Income before cumulative effect of a change in accounting principle, net of tax	0.39	0.23	0.29	0.31
Net income	0.34	0.23	0.29	0.31

(i) *The sum of the quarterly earnings per share amounts may not equal the year-to-date earnings per share amounts due to rounding.*

NOTE 18 – FOHP, Inc.

In 1997, the Company purchased convertible and nonconvertible debentures of FOHP, Inc., a New Jersey corporation ("FOHP"), in the aggregate principal amounts of approximately $80.7 million and $24.0 million, respectively. In 1997 and 1998, the Company converted certain of the convertible debentures into shares of Common Stock of FOHP, resulting in the Company owning 99.6% of the outstanding common stock of FOHP. The nonconvertible debentures mature on December 31, 2002.

Effective January 1, 1999, Physicians Health Services of New Jersey, Inc., a New Jersey HMO wholly-owned by the Company, merged with and into First Option Health Plan of New Jersey ("FOHP-NJ"), a New Jersey HMO subsidiary of FOHP, and FOHP-NJ changed its name to Physicians Health Services of New Jersey, Inc. ("PHS-NJ"). Effective July 30, 1999, upon approval by the stockholders of FOHP at a special meeting, a wholly-owned subsidiary of the Company merged into FOHP and FOHP became a wholly-owned subsidiary of the Company. In connection with the merger, the former minority shareholders of FOHP are entitled to receive either $0.25 per share (the value per FOHP share as of December 31, 1998 as determined by an outside appraiser) or payment rights which entitle the holders to receive as much as $15.00 per payment right on or about July 1, 2001, provided certain hospital and other provider participation conditions are met. Also in connection with the merger, additional consideration of $2.25 per payment right will be paid to certain holders of the payment rights if PHS-NJ achieves certain annual returns on common equity and the participation conditions are met. As of December 31, 2000, the Company determined that it is probable that these payment rights would be paid on or about July 1, 2001. Accordingly, the Company recorded a purchase price adjustment of $33.7 million to goodwill as of December 31, 2000.

NOTE 19 – Subsequent Events

In January 2001, the Company entered into a definitive agreement to sell its Florida health plan, known as Foundation Health, a Florida Health Plan, Inc., to Florida Health Plan Holdings II, LLC for $48 million which consists of $23 million in cash and a $25 million secured five-year note bearing 8 percent interest. The transaction is expected to close in the second quarter of 2001 subject to regulatory approvals and other customary conditions of closing.

On February 14, 2001, the Connecticut State Medical Society filed a complaint in Connecticut State Court against Physicians Health Services of Connecticut, Inc. alleging violations of the Connecticut Unfair Trade Practices Act. The complaint alleges that PHS-CT engaged in conduct that was designed to delay, deny, impede and reduce lawful reimbursement to physicians who rendered medically necessary health care services to PHS-CT health plan members. The complaint, which is similar to others filed against the Company and other managed care companies, seeks declaratory and injunctive relief. The Company intends to vigorously defend the action.

On February 14, 2001, a purported class action lawsuit was filed in Connecticut State Court against Physicians Health Services of Connecticut, Inc. by Kevin Lynch, M.D. and Karen Laugel, M.D. on behalf of physician members of the Connecticut State Medical Society who provide health care services to PHS-CT health plan members pursuant to provider service contracts. The complaint alleges that PHS-CT engaged in improper, unfair and deceptive practices by denying, impeding and/or delaying lawful reimbursement to physicians. The complaint, similar to the complaint referred to above filed against PHS-CT on the same day by the Connecticut State Medical Society, seeks declaratory and injunctive relief, and damages. The Company intends to vigorously defend the action.

In Memory of

Karen A. Coughlin
February 2, 1948 — November 29, 2000

Karen A. Coughlin led Health Net, Inc.'s Northeast Division from November 1998 to November 29, 2000.

In her two short years with Health Net, Karen turned around Health Net's Northeast operations and was an important force in creating one of the region's leading health plans. Prior to joining Health Net, Inc., Karen served a long and distinguished tenure with Humana, Inc., where she worked for 18 years in several executive positions.

Karen's career in health care spanned more than 30 years. She began her career at the bedside, serving as head nurse of the Pediatric Intensive Care Unit at Loma Linda University Medical Center in California. She also served as assistant professor of Nursing for Minot State University in North Dakota and as a staff nurse in the Neonatal Intensive Care Unit for Cleveland's Fairview General Hospital.

Karen touched many lives in her own unique and passionate way, both inside and outside of Health Net, and her legacy and spirit will continue to live on for all who knew her.

Karen is survived by two children, five sisters, two brothers, three grandchildren, many nieces and nephews and her fiancé, Lawrence O'Gara.

Mary Gilligan
March 5, 1959 — January 9, 2001

Mary Gilligan served as president and chief executive officer of Health Net of Arizona from January 2000 to January 9, 2001.

Mary was a seasoned health care professional with more than 20 years of experience in the health care industry. Prior to leading Health Net of Arizona (formerly known as Intergroup of Arizona), Mary served as the chief operating officer of United-Healthcare of Illinois, where she was responsible for all aspects of commercial and government operations.

From 1996 through 1998, Mary served as senior vice president of operations for Health Net of California. Prior to that, Mary served in several executive positions for Blue Cross Blue Shield of Washington, DC; Lifeguard, Inc.; and Cigna Companies of Arizona. Mary began her health care career at Saint Luke's Hospital in Duluth, Minnesota where she served as a Registered Nurse.

Mary put her own special touch on all she did and brought a sense of energy and family to Health Net of Arizona. She will be missed for the person she was as much as for the leadership she provided.

Mary is survived by her husband, James Gilligan, and her daughter Jessica.

Corporate Information

BOARD OF DIRECTORS:

Richard W. Hanselman, [2]
Chairman of the Board
Health Net, Inc.
Corporate Director and Consultant

J. Thomas Bouchard [3]
Former Senior Vice President of Human Resources
International Business Machines (IBM) Corporation

Governor George Deukmejian [1,2]
Former Partner
Sidley & Austin

Thomas T. Farley [1,3]
Senior Partner
Petersen & Fonda, P.C.

Gale S. Fitzgerald*
Former Chair and Chief Executive Officer
Computer Task Group, Inc.

Patrick Foley [3,4,5]
Former Chairman, President and Chief Executive Officer
DHL Airways, Inc.

Jay M. Gellert
President and Chief Executive Officer
Health Net, Inc.

Roger F. Greaves [2,4,5]
Former Co-Chairman of the Board of Directors, Co-President and Co-Chief Executive Officer
Health Systems International, Inc.

Richard J. Stegemeier [1,4]
Chairman Emeritus
Unocal Corporation

Raymond S. Troubh [3,4]
Financial Consultant

Bruce G. Willison [1,5]
Dean
The Anderson School at the University of California, Los Angeles (UCLA)

BOARD COMMITTEES:

[1] *Audit Committee*
[2] *Committee on Directors*
[3] *Compensation and Stock Option Committee*
[4] *Finance Committee*
[5] *Technology/Infrastructure Committee*
* *Appointed to the Board of Directors on March 2, 2001*

EXECUTIVE OFFICERS

Jay M. Gellert
President and Chief Executive Officer

Jeffrey J. Bairstow
President, Government and Specialty Services Division

Steven P. Erwin
Executive Vice President and Chief Financial Officer

Karin D. Mayhew
Senior Vice President, Organization Effectiveness

Timothy J. Moore, M.D.
Senior Vice President and Chief Medical Officer

Cora M. Tellez
President, Health Plans Division

Gary S. Velasquez
President, Business Transformation and Innovation Services Division

B. Curtis Westen, Esq.
Senior Vice President, General Counsel and Secretary

CORPORATE OFFICES

21650 Oxnard Street
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(818) 676-6000
www.health.net

INDEPENDENT AUDITORS

Deloitte & Touche LLP
Los Angeles, California

STOCK TRANSFER AGENT AND REGISTRAR

Computershare Investor Services
Chicago, Illinois

ANNUAL REPORT ON FORM 10-K

A stockholder may receive, without charge, a copy of the Health Net, Inc. Annual Report on Form 10-K for the year ended December 31, 2000, filed with the Securities and Exchange Commission, by writing to the following: Investor Relations, Health Net, Inc., 21650 Oxnard Street, Woodland Hills, California 91367 or by calling (800) 291-6911.

MARKET DATA OF HEALTH NET, INC.

Class A Common Stock
Traded: New York Stock Exchange
Symbol: HNT

2001 ANNUAL MEETING

The 2001 Annual Meeting of Stockholders will be held at 10:00 a.m. PDT on May 3, 2001, at the Hilton Woodland Hills, 6360 Canoga Avenue, Woodland Hills, California 91367, and via the Internet at www.health.net.

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CALIFORNIA 91367