HEALTH NET, INC.

INDEX TO FORM 10-K

	Page
PART I.	
Item 1—Business	1
General	1
Segment Information	1
Provider Relationships	12
Additional Information Concerning Our Business	13
Government Regulation	17
Intellectual Property	22
Employees	22
Dependence Upon Customers	22
Shareholder Rights Plan	22
Potential Acquisitions and Divestitures	23
Item 1A—Risk Factors	23
Item 1B—Unresolved Staff Comments	56
Item 2—Properties	56
Item 3—Legal Proceedings	56
Item 4—Mine Safety Disclosures.	58
PART II.	
Item 5—Market For Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	59
Item 6—Selected Financial Data	63
Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operations	65
Item 7A—Quantitative and Qualitative Disclosures About Market Risk	101
Item 8—Financial Statements and Supplementary Data	102
Item 9—Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	102
Item 9A—Controls and Procedures	102
Item 9B—Other Information	105
PART III.	
Item 10—Directors, Executive Officers of the Registrant and Corporate Governance	106
Item 11—Executive Compensation	106
Item 12—Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	106
Item 13—Certain Relationships and Related Transactions, and Director Independence	106
Item 14—Principal Accountant Fees and Services	106
PART IV.	
Item 15—Exhibits and Financial Statement Schedule	107

SIGNATURES CDIX371	108
Index to Consolidated Financial Statements	F-1
Report of Independent Registered Public Accounting Firm	F-2
Supplemental Schedule	F-63

-

PART I

Item 1. Business.

General

We are a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. Our mission is to help people be healthy, secure and comfortable. In this Annual Report on Form 10-K, unless the context otherwise requires, the terms “Company,” “Health Net,” “we,” “us,” and “our” refer to Health Net, Inc. and its subsidiaries. We provide and administer health benefits to approximately 6.0 million individuals across the country through group, individual, Medicare (including the Medicare prescription drug benefit commonly referred to as "Part D"), Medicaid, dual eligible, U.S. Department of Defense (“Department of Defense” or “DoD”), including TRICARE, and U.S. Department of Veterans Affairs programs. Through our subsidiaries, we also offer behavioral health, substance abuse and employee assistance programs, managed health care products related to prescription drugs, managed health care product coordination for multi-region employers, and administrative services for medical groups and self-funded benefits programs.

We were incorporated in 1990. Our current operations are the result of the April 1, 1997 merger transaction (the "FHS Combination") involving Health Systems International, Inc. ("HSI") and Foundation Health Corporation. We changed our name to Health Net, Inc. in November 2000. Prior to the FHS Combination, we were the successor to the business conducted by Health Net of California, Inc., now our HMO subsidiary in California, and HMO and PPO networks operated by QualMed, Inc., which combined with us in 1994 to create HSI.

Our executive offices are located at 21650 Oxnard Street, Woodland Hills, California 91367, and our Internet website address is *www.healthnet.com.*

We make available free of charge on or through our Internet web site, *www.healthnet.com*, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K and all amendments to those reports filed or furnished pursuant to Section 13(a) or Section 15(d) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”) as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission (“SEC”). Such materials also are available free of charge on the SEC website, *www.sec.gov*. Copies of our Corporate Governance Guidelines, Code of Business Conduct and Ethics, Director Independence Standards and charters for the Audit Committee, Compensation Committee, Governance Committee and Finance Committee of our Board of Directors also are available on our Internet website. We will provide electronic or paper copies free of charge upon request. Please direct your written request to Investor Relations, Health Net, Inc., 21650 Oxnard Street, Woodland Hills, California 91367, or contact Investor Relations by telephone at (818) 676-6000. We have included our and the SEC’s Internet website addresses throughout this Annual Report on Form 10-K as textual references only. The information contained on these websites is not incorporated into this Annual Report on Form 10-K.

Our transfer agent, Wells Fargo, can help you with a variety of shareholder-related services, including change of address, lost stock certificates, transfer of stock to another person and other administrative services. You can write to our transfer agent at: Wells Fargo Shareowner Services, P.O. Box 64854, St. Paul, Minnesota 55164-0854, email stocktransfer@wellsfargo.com, or telephone (800) 468-9716 or (651) 450-4064.

Segment Information

Our reportable segments for 2014 are comprised of Western Region Operations and Government Contracts. Effective January 1, 2013, our Divested Operations and Services was closed out after completion of transition and run-out activities related to our sold businesses as discussed below. For additional financial information regarding our reportable segments, see “—Results of Operations” in “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations” and Note 14 to our consolidated financial statements included as part of this Annual Report on Form 10-K.

Western Region Operations Segment

Our Western Region Operations segment includes the operations of our commercial, Medicare and Medicaid health plans as well as the operations of our health and life insurance companies and certain operations of our behavioral health and pharmaceutical services subsidiaries, primarily in Arizona, California, Oregon and Washington. As of December 31, 2014, we had approximately 3.2 million risk members in our Western Region Operations segment.

Managed Health Care Operations

We offer a full spectrum of managed health care products and services. Our strategy is to create affordable and tailored customer solutions by (i) seeking to provide product offerings that both anticipate and respond to current and emerging market demands; (ii) pursuing innovative provider relationships that effectively manage the cost of care; and (iii) building alliances with other stakeholders in the health care system to identify and implement changes to help improve the quality and accessibility of the health care system. The pricing of our products is designed to reflect the varying costs of health care based on the benefit alternatives in our products. Our health plans offer members coverage for a wide range of health care services including ambulatory and outpatient physician care, hospital care, pharmacy services, behavioral health and ancillary diagnostic and therapeutic services. Our health plans include a matrix package, which allows employers and members to select their desired coverage from a variety of alternatives. Our principal commercial health care products are as follows:

- *HMO Plans*: Our health maintenance organization or HMO plans offer comprehensive benefits generally for a fixed fee or premium that does not vary with the extent or frequency of medical services actually received by the member. We offer HMO plans with differing benefit designs and varying levels of co-payments at different premium rates. These plans are offered generally through contracts with participating network physicians, hospitals and other providers. When an individual enrolls in one of our HMO plans, he or she selects a primary care physician ("PCP") from among the physicians participating in our network. PCPs generally are family practitioners, general practitioners or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care services, including making referrals to participating network specialists. In California, participating providers are typically contracted through medical groups and independent physician associations. In those cases, enrollees in HMO plans are generally required to secure specialty professional services from physicians in the group, as long as such services are available from group physicians. A significant majority of our California membership is in HMO plans.
- *PPO Plans*: Our preferred provider organization or PPO plans offer coverage for services received from any health care provider, with benefits generally paid at a higher level when care is received from a participating network provider. Coverage typically is subject to deductibles and co-payments or coinsurance.
- *POS and EOA Plans:* Our point of service or POS plans and our elect open access or EOA plans blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits for services received from participating network providers with lower copayments (particularly within the medical group), but also have coverage, generally at higher copayment or coinsurance levels or with coverage limitations, for services received outside the network.
- *EPO Plans and HSP:* Our Exclusive Provider Organization or EPO plans and Healthcare Service Plans or HSP similarly blend elements of traditional HMO and PPO plans. Referrals are not required for in-network specialty care, but there are no out of network benefits other than emergency care. In some, but not all, plans members select a PCP that coordinates most care.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") has altered and continues to alter the dynamics of the health care insurance industry. The breadth and scope of these changes have presented us with a number of new and substantial business opportunities as well as a number of strategic and operational challenges. Among other things, the ACA required the modification of existing commercial products and the development of new products beginning with the 2014 benefit year. In response, we developed new health plans both for the ACA's individual health insurance exchanges and for off-exchange use that met the ACA's essential health benefits standard and other requirements. These products incorporated new cost sharing features as required by the ACA. Whether sold through the exchange or off-exchange, these products also had to meet the requirements of four "metal" tiers-Bronze, Silver, Gold and Platinum. Plans offered in each tier have to achieve a prescribed actuarial value. On the exchanges we must offer at least one silver and one gold product. We also offer catastrophic plans. For additional information on the exchanges, see "—Western Region Exchanges."

In recent years, the health care industry has seen a renewed interest in the managed care model. The evolving health care landscape, including the changes presented by the ACA and related state initiatives and regulations, have, among other things, resulted in increased popularity of health care delivery systems that focus on coordination of care and cost management, particularly through the use of fixed payment models, otherwise referred to as capitation. A recent example is California's Coordinated Care Initiative, or "CCI," which required that California Medicaid ("Medi-Cal") beneficiaries in the participating CCI counties receive their benefits from managed care health plans. For additional information on the CCI, see "—California Coordinated Care Initiative."

In addition, we believe that economic pressures have caused customers (both individuals and employer groups) increasingly to make health insurance purchasing decisions based on "value versus choice." We believe that many customers are choosing health plans that offer better financial value over health plans that may offer broader networks that require higher premiums. We have developed and are selling products using tailored networks to meet this need. These tailored network products use dedicated provider networks that share our commitment to quality health care and affordability. These products also incorporate benefit levels that help ensure our members have access to the care they need.

We offer tailored network HMO, EPO or HSP products throughout our Western Region Operations segment. These products are structured in a variety of ways. They may include a tiered provider option, be organized in conjunction with a strategic provider partner or be created specifically for particular populations and geographically proximate networks. For example, our HMO CommunityCare℠ product offers a network of HMO doctors, specialists and hospitals designed to meet the unique needs of the individual exchange markets. Our Salud Con Health Net℠ product line is a suite of affordable plans developed for the Latino community. In addition, we have developed tailored network products with strategic provider partners in California, Arizona, Oregon and Washington, and we have developed customized products for large employer groups with a large geographic distribution within a particular state. We believe our strength in tailored network products has been an important factor in the enrollment growth that we experienced in 2014 in both our on-exchange and off-exchange HMO, EPO or HSP plans that utilize tailored networks.

We assume both underwriting and administrative expense risk in return for the premium revenue we receive from our HMO, POS, PPO/EOA and HSP products. In California, under a capitation payment model, we pay a provider group a fixed amount per member on a regular basis, usually monthly, and the provider group accepts the risk of the frequency and cost of member utilization of professional services. We believe that capitation payment models incentivize providers to focus more on preventive care and cost management. Under these payment models, we believe members are more likely to receive a comprehensive array of appropriate and timely preventive services than in fee-for-service models, thereby helping to improve members' health, reduce the need for more costly acute care interventions and, in so doing, lower the rate of growth of health care costs. With its focus on improving patient care through shared risk amongst providers and health insurers, the capitation payment model shares certain similarities with the Accountable Care Organization ("ACO") model that is one of the ACA's primary initiatives for improving the quality and efficiency of health care delivery systems. See "—Provider Relationships" for additional information about our capitation fee arrangements and "Item 1A. Risk Factors-*If we fail to develop and maintain satisfactory relationships on competitive terms with the hospitals, provider groups and other providers that provide services to our members, our profitability could be adversely affected*" for additional information on the challenges we face with providers in the changing health care environment. As of December 31, 2014, approximately 67% of our California commercial membership was enrolled in capitated medical groups. In addition, approximately 70% of our Medicare, 73% of our Medicaid and all of our dual eligibles businesses are linked to capitated provider groups.

As of December 31, 2014, 63% of our commercial members in our Western Region Operations segment were covered by conventional HMO products, 34% were covered by POS and PPO products, and 3% were covered by other related products.

Membership in our tailored network products was approximately 50% of total commercial membership as of December 31, 2014, compared with 38% as of December 31, 2013. As of December 31, 2014, approximately 64% of our California commercial capitated membership was enrolled in tailored network products.

The following table contains membership information relating to our commercial large group (generally defined as an employer group with more than 50 employees) members, commercial small group (defined as employer groups with 2 to 50 employees) members, commercial individual members, Medicare Advantage members, Medicaid members, and dual eligibles members as of December 31, 2014 (our Medicare, Medicaid and dual eligibles businesses are discussed below under "—Medicare Products," "—Medicaid and Related Products" and "—California Coordinated Care Initiative," respectively):

Commercial—Large Group	546,523	(a)
Commercial—Small Group	313,073	(b)
Commercial—Individual	332,082	(c)
Medicare Advantage	274,781	
Medicaid	1,675,801	
Dual Eligibles	16,426	

____

(a) Includes 360,901 HMO members, 92,849 POS members, 58,802 PPO members, 9,461 EPO members and 24,510 members in other related products.
(b) Includes 153,299 HMO members, 21,021 POS members, 137,717 PPO members and 1,036 EPO members.
(c) Includes 233,696 HMO members, 2,842 POS members, 95,521 PPO members, and 23 EPO members.

As of December 31, 2014, our total membership was comprised of approximately 38% commercial, 8% Medicare Advantage, 53% Medicaid, and 1% dual eligibles. As of December 31, 2014, our commercial enrollment was comprised of approximately 46% large group, 26% small group and 28% individual accounts. Our membership in individual accounts increased from 11% of our commercial enrollment as of December 31, 2013, driven in large part by membership increases in the health insurance exchanges, which are further described below under the heading "—*Western Region Exchanges*."

The following table sets forth certain information regarding our employer groups in the commercial managed care operations of our Western Region Operations segment as of December 31, 2014:

Number of Employer Groups	27,965	
Largest Employer Group as % of commercial enrollment	9.0	%
10 largest Employer Groups as % of commercial enrollment	21.4	%

Detailed membership information regarding our health plan operations in Arizona, California, Oregon and Washington health plans is set forth below. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations—Western Region Operations Reportable Segment—Western Region Operations Segment Membership" for a discussion on changes in our membership levels during 2014.

Arizona. Our Arizona health plan operations are conducted by our subsidiaries, Health Net of Arizona, Inc., Health Net Access, Inc. and Health Net Life Insurance Company ("HNL"). Our commercial membership in Arizona was 178,064 including 60,743 tailored network members, as of December 31, 2014. Our Medicare Advantage membership in Arizona was 45,873 as of December 31, 2014. Our Medicaid membership in Arizona was 80,913 as of December 31, 2014.

California. In California, our health plan operations are conducted by our subsidiaries Health Net of California, Inc. ("HN California"), Health Net Community Solutions, Inc. ("HNCS"), and HNL. HN California, our California HMO for commercial and Medicare Advantage programs, and HNCS, our California HMO for Medicaid programs, together constitute one of the largest HMOs in California as measured by total membership and together have one of the largest provider networks in California. Our commercial membership in California as of December 31, 2014 was 957,495, including 523,890 tailored network members. Our Medicare Advantage membership in California as of December 31, 2014 was 172,554. Our Medicaid membership in California as of December 31, 2014 was 1,594,888 members. Our dual eligibles membership in California as of December 31, 2014 was 16,426 members.

Northwest. The Northwest includes our Oregon and Washington health plan operations, which are conducted by our subsidiaries, Health Net Health Plan of Oregon, Inc. ("HNOR") and HNL. Our commercial membership in Oregon was 47,646 including 8,240 tailored network members, as of December 31, 2014. Our commercial membership in Washington was 8,473 as of December 31, 2014. Our Medicare Advantage membership in Oregon and Washington was 56,354 as of December 31, 2014. We did not have any Medicaid members in Oregon or Washington as of December 31, 2014.

Medicaid and Related Products

We are one of the two largest Medicaid managed care health plans in California based on membership as of December 31, 2014. We experienced significant growth in our Medicaid business during 2014, primarily the result of Medicaid expansion under the ACA, which is discussed in further detail below under the heading "—*Medicaid Expansion and Recent State Legislation*." As of December 31, 2014, we had 1,594,888 members enrolled in Medi-Cal and other California state health programs, and we had 80,913 Medicaid members enrolled in Arizona.

California

To enroll in our Medi-Cal products, an individual must be eligible for Medicaid benefits in accordance with California's regulatory requirements. The State of California's Department of Health Care Services ("DHCS") pays us a monthly fee for the coverage of our Medicaid members. The monthly fee is based on prepaid payment rates that are required by federal law to be actuarially sound, and ultimately determined by the State. The State considers a combination of various factors in setting these rates, including, without limitation, geographic area, a member's health status, age, gender, county or region, benefit mix and member eligibility category. See “Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations—Western Region Operations Reportable Segment—Western Region Operations Segment Membership” for detailed information regarding our Medicaid enrollment.

Medi-Cal is a public health insurance program that provides health care services for low-income individuals residing in California, and is financed by the state of California and the federal government. As of December 31, 2014, through HNCS, we had Medi-Cal operations in 12 California counties: Fresno, Kern, Kings, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Stanislaus and Tulare. We are the sole commercial plan contractor with DHCS to provide Medi-Cal services in Los Angeles County, California. As of December 31, 2014, 848,898 of our Medi-Cal members resided in Los Angeles County, representing approximately 53% of our Medi-Cal membership.

In November 2012, we entered into a state-sponsored health plans rate settlement agreement (the "Agreement") with DHCS to settle certain rate disputes related to prior years. Under the Agreement, DHCS agreed, among other things, to the extension of all of our Medi-Cal managed care contracts existing on the date of the Agreement, including our contract with DHCS to provide Medi-Cal services in Los Angeles County, for an additional five years from their existing expiration dates. As a result, our agreement to provide Medi-Cal services in Los Angeles County is currently scheduled to expire by its terms on March 31, 2019. The Agreement also established an account to track retrospective premium adjustments on all of our state-sponsored health care programs, including Medi-Cal, which includes our seniors and persons with disabilities population—also referred to as the aged, blind and disabled (“SPDs”), our participation in the dual eligibles demonstration portion of the CCI that began in April 2014 and Medi-Cal expansion populations (our “state-sponsored health care programs”) that also began in 2014. These retrospective premium adjustments are designed to help maintain minimum pretax margins with respect to our Medi-Cal operations. For additional information on the Agreement, see Note 2 to our consolidated financial statements, under the heading "Health Plan Services Revenue Recognition," to our consolidated financial statements included as part of this Annual Report on Form 10-K.

Arizona

In March 2013, we were awarded a contract by the Arizona Health Care Cost Containment System ("AHCCCS") to administer Medicaid benefits in Maricopa County, Arizona, beginning on October 1, 2013. AHCCCS uses federal, state and county funds to provide health care coverage to the State’s acute and long-term care Medicaid populations, low income groups and small businesses. Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a federal Section 1115 Medicaid waiver authority that allows for the operation of a total managed care model. AHCCCS contracts for acute care services in seven geographic service areas that include 15 Arizona counties. Our contract for Maricopa County has an initial term of three years with two additional one-year extensions. In accordance with AHCCCS contractual requirements, we established a subsidiary, Health Net Access, Inc., whose sole activity is to perform the obligations under the AHCCCS contract.

AHCCCS makes monthly prospective capitation payments to contracted health plans responsible for the delivery of care to members. As with our monthly fee under Medi-Cal, the monthly fee is based on prepaid payment rates that are required by federal law to be actuarially sound, and ultimately determined by the State. The State considers a combination of various factors in setting these rates, including, without limitation, geographic area, a member's health status, age, gender, county or region, benefit mix and member eligibility category.

Medicaid Expansion and Recent State Legislation

In connection with the ACA, the federal government extended funds to those states that opted to expand Medicaid eligibility from a pool that included residents with incomes up to 100% of the federal poverty level (“FPL”) to an expanded pool of residents with incomes up to 133% of the FPL. Both Arizona and California are amongst the states that have opted into this “Medicaid expansion,” which has increased and is expected to continue to increase our Medicaid membership.

California also recently enacted a bill under which DHCS expanded the list of benefits that we are required to provide to our Medi-Cal population. Under this legislation, which became effective as of January 1, 2014, we began administering certain mental health outpatient benefits to all our Medi-Cal members, including those newly eligible as a result of Medicaid expansion, and closely coordinating mental health and substance abuse services activities with county mental health departments.

California Coordinated Care Initiative

In 2012, the California legislature enacted the Coordinated Care Initiative, or "CCI." The stated purpose of the CCI is to provide a more efficient health care delivery system and improved coordination of care to individuals that are fully eligible for Medicare and Medi-Cal benefits, or "dual eligibles," as well as to all Medi-Cal only beneficiaries who rely on long-term services and supports, or "LTSS," which includes institutional long-term care and home and community-based services and other support services.

In participating counties, the CCI established a voluntary "dual eligibles demonstration," also referred to as the "Cal MediConnect" program, to coordinate medical, behavioral health, long-term institutional, and home- and community-based services for dual eligibles through a single health plan, and requires that all Medi-Cal beneficiaries in participating counties join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS. The DHCS selected eight counties to participate in the CCI, including Los Angeles and San Diego counties. On April 4, 2012, DHCS selected us to participate in the dual eligibles demonstration for both Los Angeles and San Diego counties. In December 2013, HNCS entered into a three-way agreement with DHCS and CMS, which was subsequently amended on January 13, 2014 (the "Cal MediConnect Contract"). Among other things, under the Cal MediConnect Contract we have received and expect to continue to receive prospective blended capitated payments to provide coverage for dual eligibles in Los Angeles and San Diego Counties.

In January 2014, CMS and DHCS informed us that based on its readiness assessments, we were able to enroll members beginning April 1, 2014, and could begin marketing for the dual eligibles demonstration in accordance with the guidelines and timeframes for Los Angeles and San Diego counties. Active enrollment in Los Angeles and San Diego counties for the dual eligible demonstrations commenced on April 1, 2014, and is scheduled to conclude at the end of 2017. During the active enrollment period, dual eligibles in Los Angeles County are able to either choose among us, the local health plan initiative, or one of three other health plans for benefits under the dual eligibles demonstration. On July 1, 2014, DHCS began automatically enrolling dual eligibles in Los Angeles County who have not selected a health plan, which we refer to as "passive enrollment." Dual eligibles also may choose to "opt out" of the demonstration at any time. Such dual eligibles will then continue to receive Medicare services through either fee-for-service Medicare or the Medicare Advantage program, but will receive Medi-Cal benefits through a managed care health plan as required under the CCI. During the active enrollment period in San Diego County, dual eligibles are able to select to receive benefits from any one of four health plan options, including us, or "opt out" of the demonstration. Passive enrollment in San Diego County began on May 1, 2014. Based on our understanding of the passive enrollment methodology, we estimate that Health Net will receive approximately 47% and 20–25% of the passively enrolled dual eligibles in Los Angeles County and San Diego County, respectively. As of December 31, 2014, we had 16,426 dual eligibles members.

Health Net's participation in the CCI, and the dual eligibles demonstration in particular, represents a significant business opportunity for us, but is subject to a number of risks inherent in untested health care initiatives, particularly those that involve new populations with limited cost experience. See "Item 1A. Risk Factors—*Our participation in the dual eligibles demonstration portion of the California Coordinated Care Initiative in Los Angeles and San Diego Counties may prove to be unsuccessful for a number of reasons*" for a discussion of some of the risks associated with our participation in the CCI.

The managed care services provided by HNCS to enrollees under the Cal MediConnect Contract include medical, prescription drug, LTSS, and behavioral health services. HNCS's responsibilities under the Cal MediConnect Contract also include providing traditional managed care services, including quality improvement, grievance and appeals, provider network establishment, and utilization management functions. HNCS also performs care coordination, case management services and health risk assessments, and develops individualized care plans for enrollees. We have developed our model for managing LTSS, building on our internal expertise and utilizing expert vendor resources to fulfill certain functions, including the risk stratification and health risk assessment (HRA) services required under the program. We have also developed our provider network for LTSS, including contracting with and training a variety of ancillary providers and capitated provider groups with a demonstrated capability for managing long-term care patients.

Compensation. Under the Cal MediConnect Contract, we are compensated on a capitated, prospective per-member-per-month basis, subject to CMS and DHCS modification of the capitation rates, which are currently based on the historical fee-for-service cost for providing care to dual eligibles. The Cal MediConnect Contract includes a risk adjustment process that adjusts the capitation payment to HNCS based on the health characteristics of the enrollee population, and includes risk corridor provisions that limit our upside financial gains and reduce our downside financial risk. DHCS and CMS also withhold a portion of capitation payments pending and payable upon satisfaction of certain pre-established quality standards. The financial performance of the Cal MediConnect Contract is included in the calculation of the settlement account that was established pursuant to the terms of the Settlement Agreement entered into by DHCS, HNCS and Health Net of California, Inc. on November 2, 2012, which is further discussed above under the heading "—*Western Region Operations Segment—Medicaid and Related Products.*"

Term and Termination. Assuming that no party elects to terminate or not to renew the Cal MediConnect Contract, the dual eligibles demonstration will continue through December 31, 2017. CMS or DHCS may immediately terminate the Cal MediConnect Contract for various reasons, or may terminate for no reason with 180 days' prior written notice.

Western Region Exchanges

The ACA required the establishment of state-run or federally facilitated "exchanges" where individuals and small groups may purchase health coverage. California and Oregon received approval by the U.S. Department of Health and Human Services ("HHS") and began operating state-run exchanges in 2013. HHS operates the exchange in Arizona.

We currently participate as Qualified Health Plans ("QHPs") in the exchanges in California and Arizona. Open enrollment for the coverage year beginning January 1, 2015 began on October 1, 2014 and ended on February 15, 2015. Continued participation in these exchanges and future participation in any other exchanges in the states in which we operate may be conditioned on the approval of the applicable state or federal government regulator, which could result in the exclusion of some carriers from the exchanges. Certain factors to be considered for continued participation in the exchanges may be subject to change. We believe the exchanges represent a significant commercial business opportunity for us, and the growth we experienced through the first open enrollment period demonstrated that our tailored network products are particularly well suited to the exchange environment as demonstrated by the 21% of market share we acquired in the first year of the exchanges with 81% of that concentrated in our tailored network offerings as of December 31, 2014. As of December 31, 2014, we had approximately 269,784 active individual members through the California, Arizona and Oregon exchanges, including 182,962 in our Silver tier HMO product, CommunityCare℠.

We have made and are continuing to make significant efforts to design and implement a cohesive operational and economic strategy with respect to the exchanges and the ACA's other relevant provisions, including premium stabilization provisions designed to apportion risk amongst insurers. Implementation of the exchanges remains ongoing, as significant portions of the insurance market, including small business groups, are expected to enter the exchanges for the first time in 2015. Moreover, in the second year of the exchanges, we expect that the marketplace will react to the pricing data, information and other feedback that is and becomes available following the completion of the first year of the exchanges. Accordingly, we will need to continue to monitor this market and remain nimble in our strategic approach. This changing framework may alter the economics and structure of our participation in the exchanges, and if we are not able to successfully adapt to any such changes in certain areas of our markets, our financial condition, cash flows and results of operations may be adversely affected. For a discussion of the risks related to the exchanges, and the state and federal government actions impacting the exchanges and the effect on our competitive landscape, see "Item 1A. Risk Factors—*Federal health care reform legislation has had and will continue to have an adverse impact on the costs of operating our business and a failure to successfully execute our operational and strategic initiatives with respect thereto could adversely affect our business, cash flows, financial condition and results of operations*," and "—*Various health insurance reform proposals are also emerging at the state level, which could have an adverse impact on us.*"

In the Arizona individual market we offer HMO products in three counties and PPO plans statewide both through the exchange and off-exchange. We offer HMO and PPO products to small business groups statewide both through the exchange and off-exchange. We currently operate in 13 of 19 exchange rating regions in California in the individual market, and in all 19 California exchange rating regions in the small business health options program ("SHOP"). In Southern California, we offer HMO and HSP products in the individual market that collectively cover all metal tiers and the catastrophic category level and offer PPO and EPO products that collectively cover all metal tiers in the SHOP. Outside of Southern California, we offer EPO products in the individual market that cover all metal tiers and the catastrophic category level and offer PPO and EPO products that collectively cover all metal tiers in the SHOP.

Medicare Products

We provide a wide range of Medicare products, including Medicare Advantage plans with and without prescription drug coverage and Medicare supplement products that supplement traditional fee-for-service Medicare coverage. Our subsidiaries have a number of contracts with the Centers for Medicare & Medicaid Services ("CMS") under the Medicare Advantage program authorized under Title XVIII of the Social Security Act of 1935, as amended.

Medicare Advantage Products

As of December 31, 2014, we were one of the nation's largest Medicare Advantage contractors based on membership of 274,781 members. We contract with CMS under the Medicare Advantage program to provide Medicare

Advantage products directly to Medicare beneficiaries and through employer and union groups. We provide or arrange health care benefits for services normally covered by Medicare, plus a broad range of health care benefits for services not covered by traditional Medicare, usually in exchange for a fixed monthly premium per member from CMS that varies by the county in which the member resides, demographic factors of the member such as age, gender and institutionalized status, and the health status of the member. Any benefits that are not covered by Medicare may result in an additional monthly premium charged to the enrollee or through portions of payments received from CMS that may be allocated to these benefits, according to CMS regulations and guidance. Many of our Medicare Advantage members pay no monthly premium to us for these additional benefits.

Our portfolio of Medicare Advantage plans focuses on simplicity so that members can use benefits with minimal paperwork and receive coverage that starts immediately upon enrollment. We also provide Medicare supplemental coverage to 28,801 members as of December 31, 2014 through either individual Medicare supplement policies or employer group sponsored coverage.

We provide Medicare Advantage plans in select counties in Arizona, California, Oregon and Washington, and provide prescription drug benefits in most of our Medicare Advantage plan offerings. We also provide multiple types of Medicare Advantage Special Needs Plans, including dual eligible Special Needs Plans (designed for low income Medicare beneficiaries) in Arizona and California, chronic condition Special Needs Plans (designed for beneficiaries with congestive heart failure and diabetes) in California, Oregon and Arizona. These plans provide access to additional health care and prescription drug coverage.

CMS developed the Medicare Advantage Star Ratings system to help consumers choose among competing plans, awarding between one and five stars to Medicare Advantage plans based on performance in certain measures of quality. The Star Ratings are used by CMS to award quality bonus payments to Medicare Advantage plans. Beginning with the 2014 Star Rating (calculated in 2013), Medicare Advantage plans were required to achieve a minimum of 4 Stars to qualify for a quality bonus payment in 2015. The methodology and measures included in the Star Ratings system can be modified by CMS annually and Star Ratings thresholds are based on performance of Medicare Advantage plans nationally.

For the 2015 Star rating (calculated in 2014 for the 2016 payment year), our California HMO and Oregon HMO and PPO contracts with CMS were measured at 4.0 Stars, our Arizona HMO contract was measured at 3.5 Stars and our California PPO contract was measured at 3.0 Stars. See "Item 1A. Risk Factors—*Medicare programs represent a significant portion of our business and are subject to risk*" for additional information on our star ratings.

Indemnity Insurance Products

We offer insured PPO, EPO and indemnity products as “stand-alone” products and as part of multiple option products in various markets. These products are offered by our health and life insurance subsidiaries, which are licensed to sell insurance in 49 states and the District of Columbia. Through these subsidiaries, we also offer auxiliary non-health products such as life, accidental death and dismemberment, dental, vision and behavioral health insurance. Our health and life insurance products are provided throughout most of our service areas.

Other Specialty Services and Products

We offer pharmacy benefits, behavioral health, dental and vision products and services (mostly through strategic relationships with third parties), as well as managed care products related to cost containment for hospitals, health plans and other entities as part of our Western Region Operations segment.

<u>Pharmacy Benefit Management</u>

We provide pharmacy benefit management (“PBM”) services to Health Net members through our subsidiary, Health Net Pharmaceutical Services (“HNPS”). As of December 31, 2014, HNPS provided integrated PBM services to approximately 3.0 million Health Net members who have pharmacy benefits, including approximately 269,000 of our Medicare members and approximately 16,000 of our dual eligibles members.

HNPS manages these benefits in an effort to achieve the highest quality outcomes at the lowest cost for Health Net members. HNPS contracts with national health care providers, vendors, drug manufacturers and pharmacy distribution networks (directly and indirectly through a third party vendor), oversees pharmacy claims and administration, reviews and evaluates new FDA-approved drugs for safety and efficacy and manages data collection efforts to facilitate our health plans' disease management programs. In addition, HNPS provides affiliated health plans various services including development of benefit designs, cost and trend management, sales and marketing support, and management delivery systems. HNPS outsources certain capital and labor-intensive functions of pharmacy benefit management, such as claims processing, mail order services and pharmacy network services.

Behavioral Health

We administer and arrange for behavioral health benefits and services through our subsidiary, Managed Health Network, Inc., and its subsidiaries (collectively “MHN”). MHN offers behavioral health, and substance abuse programs on an insured and self-funded basis to groups in various states, and these programs and services are included as a standard part of most of our commercial health plans. MHN's benefits and services are also sold in conjunction with other commercial and Medicare products and on a stand-alone basis to unaffiliated health plans and employer groups. In addition, MHN administers employee assistance programs (“EAPs”) for groups in several states. Through our EAPs, we assess and refer employees of employer groups to a variety of non-medical services and information designed to improve workplace productivity. MHN also holds contracts with the U.S. Department of State (“State Department”) and the U.S. Agency for International Development (“USAID”) to provide EAP counseling services tailored for State Department and USAID employees and family members while posted overseas. In addition, effective January 1, 2014, we are required to administer certain mental health outpatient benefits to all our Medi-Cal members, including those newly eligible as a result of Medicaid expansion.

MHN's products and services were provided to approximately 7.1 million individuals as of December 31, 2014, with approximately 147,000 individuals under risk-based programs, approximately 2.8 million individuals under self-funded programs and approximately 4.1 million individuals under EAPs, including those who are also covered under other MHN programs. In 2014, MHN's total revenues were $46.6 million. Of that amount, $3.0 million represented revenues from business with MHN affiliates and $43.6 million represented revenues from non-affiliate business. The foregoing excludes results and information related to MHN's administration and monitoring of the non-medical counseling program for the Department of Defense under the DoD sponsored Military Family and Life Counseling (“MFLC”) program formerly Military Family and Life Consultant program, which is reported in our Government Contracts reportable segment. See “—Government Contracts Segment—Other Department of Defense Contracts.”

Dental and Vision

We do not underwrite or administer stand-alone dental or vision products other than the stand-alone dental products that we underwrite in Oregon and Washington. During 2014 our current and prospective group plan members in Arizona and California had the option to elect private label dental products through a strategic relationship with Dental Benefit Providers, Inc. (“DBP”) and private label vision products through a strategic relationship with EyeMed Vision Care LLC (“EyeMed”). Those stand-alone dental products were underwritten and administered by DBP affiliated companies and the stand-alone vision products were underwritten by Fidelity Security Life Insurance Company and administered by EyeMed affiliated companies. DBP also administers dental products and coverage we provide to our members in Oregon and Washington, as well as to Medicaid enrollees in Arizona. Liberty Dental Plans of California, Inc. serves as the underwriter and administrator for the dental services we provide to our Medi-Cal enrollees. Vision Service Plan serves as the underwriter and administrator for the vision services we provide to our Medi-Cal enrollees in California and Medicaid enrollees in Arizona.

Government Contracts Segment

Our Government Contracts segment includes our government-sponsored managed care federal contract with the DoD under the TRICARE program in the North Region and other health care and behavioral health government contracts. On April 1, 2011, we began delivery of administrative services under the Managed Care Support Contract (“T-3 contract”) for the TRICARE North Region. Under the T-3 contract for the TRICARE North Region, we provide various types of administrative services including: provider network management, referral management, medical management, disease management, enrollment, customer service, clinical support service, and claims processing.

Our Government Contracts segment also includes other health care and behavioral health government contracts, and subcontracts that we administer for the DoD, the U.S. Department of Veterans Affairs (“VA”) and certain other federal, state and local government entities. Certain components of these contracts are subcontracted to unrelated third parties.

Amounts receivable under government contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract. In general, government receivables are estimates and are subject to government audit and negotiation. See “Item 1A. Risk Factors—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these* *programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations*."

TRICARE

Our wholly owned subsidiary, Health Net Federal Services, LLC ("HNFS"), is a Managed Care Support Contractor in the North Region for the DoD TRICARE program. We have been serving the DoD since 1988 under the TRICARE program and its predecessor programs, and we believe we have established a solid history of operating performance in this line of business. We believe there will continue to be further opportunities to serve the DoD and other governmental organizations, such as the VA, in the future.

We began providing services under the T-3 contract on April 1, 2011. The T-3 contract for the North Region covers Connecticut, Delaware, Illinois, Indiana, Kentucky (except Fort Campbell), Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin and the District of Columbia. In addition, the contract covers portions of the states of Iowa and Missouri.

As a Managed Care Support Contractor for the T-3 contract for the TRICARE North Region, we provide administrative services to approximately 2.8 million Military Health System ("MHS") eligible beneficiaries. Eligible active duty service members and their families, retired service members and their families, survivors of retired service members, and qualified former spouses are able to choose from a variety of TRICARE program options, including TRICARE Prime, which is similar to a conventional HMO plan. Non-active duty service members can select, on a case-by-case basis, to utilize TRICARE Extra, which is similar to a conventional PPO plan, or TRICARE Standard, which is similar to a conventional indemnity plan.

Under TRICARE Prime, enrollees pay an enrollment fee (which is zero for active duty service members and their families) and select a primary care physician from our contracted provider network. The primary care physicians are responsible for making referrals to specialists and hospitals. Active duty service members and their families enrolled in TRICARE Prime have no copayments. However, all other TRICARE Prime enrollees are subject to copayments for medical services. TRICARE Prime enrollees may opt, on a case-by-case basis, for a Point-of-Service option in which they are allowed to self-refer to a network or non-network provider, but incur a deductible and a cost-share. The Point of Service option is not available for active duty service members.

Under TRICARE Extra, eligible beneficiaries receive services from a TRICARE network provider but incur a deductible and cost-share that may be greater than the TRICARE Prime copayment. Beneficiaries utilizing TRICARE Extra realize a five percent cost-share savings over TRICARE Standard. Under TRICARE Standard, eligible beneficiaries receive services from a TRICARE authorized provider, either participating or non-participating, but incur a deductible and higher cost-share than under TRICARE Prime or TRICARE Extra. In addition, TRICARE offers premium-based health plans for eligible beneficiaries. Qualified Selected Reserve members may purchase TRICARE Reserve Select ("TRS"), which is a TRICARE Standard benefit. TRS members have the same costs as active duty family members. Qualified retired Reserve members may purchase TRICARE Retired Reserve ("TRR"), also a TRICARE Standard benefit. TRR members have the same costs as retired service members. TRICARE Young Adult ("TYA") is available for purchase by eligible young adults under age 26. TRICARE currently offers a TYA Standard plan and a TYA Prime plan.

The T-3 contract has five one-year option periods. We are currently in option period 5, which commenced on April 1, 2014 and is scheduled to end on March 31, 2015. In June 2014, at the request of the DoD, we submitted a proposal to add three additional one-year option periods to the T-3 contract. We currently expect negotiations relating to this proposal to conclude on or prior to March 31, 2015. If the negotiations conclude as expected, we expect the DoD to exercise the first of the three one-year options by that date. If all three one-year option periods are ultimately exercised, the T-3 contract would conclude on March 31, 2018. The DoD intends to re-procure managed care support services for the TRICARE program for the period beginning in 2017, and, to that end, released a draft Request for Proposals on November 3, 2014. The T-3 contract services are currently structured as cost reimbursement arrangements for health care costs plus administrative fees received in the form of fixed prices, fixed unit prices, and contingent fees and payments based on various incentives and penalties.

For additional information regarding our previous TRICARE contract for the North Region and the T-3 contract for the North Region, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Item 1A. Risk Factors—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations.*"

Military Family and Life Counseling Program.

Our wholly owned subsidiary, MHN Government Services, is party to a MFLC contract that was awarded by the Department of Defense to implement, administer and monitor the non-medical counseling MFLC program. The contract was initially awarded in August of 2012 and is a second-generation contract under the MFLC program. The contract has a five-year term that includes a 12-month base period and four 12-month option periods. The DoD has exercised the first and second option periods under the contract, and the second option period is scheduled to end on August 14, 2015. For the year ended December 31, 2014, revenues from the MFLC contract were $119.7 million. For additional information on the risks associated with our MFLC contract, see “Item 1A. Risk Factors—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations*.”

Patient Centered Community Care Program

In September 2013, VA awarded HNFS a contract under its new Patient Centered Community Care (“PC3”) program. The PC3 program provides eligible veterans coordinated, timely access to care through a comprehensive network of non-VA providers who meet VA quality standards when a local VA medical center cannot readily provide the care. We support VA in providing care to veterans in three of the six PC3 program regions. These three regions, Regions 1, 2 and 4, encompass all or portions of 37 states, the District of Columbia, Puerto Rico and the Virgin Islands. The PC3 contract term includes a base period of performance through September 30, 2014 and four one-year option periods that may be exercised by VA. On September 23, 2014, VA exercised option period 1 which commenced on October 1, 2014 and is scheduled to end on September 30, 2015. In addition to the one-year option periods, VA has the ability to extend the PC3 program contract an additional two years and six months based on VA's need.

In August 2014, VA expanded our PC3 contract to include primary care services for veterans who are unable to obtain primary care at a VA medical center in the three PC3 regions in which we operate. In addition, in November 2014, we modified our PC3 contract to further expand our services with VA in support of the Veterans Access, Choice and Accountability Act of 2014 (“VACAA”). VACAA allows eligible veterans who live more than 40 miles from a VA facility or are unable to get a VA appointment within 30 days of their preferred date, or within 30 days of the date determined medically necessary by their physician, to obtain approved care in their community instead. The VACAA modification to our PC3 contract (the "VACAA modification") expires no later than September 30, 2017. The VACAA modification includes, among other things, the production and distribution of the new Veterans Choice Card, which allows veterans to elect to receive care outside of VA when they qualify. As a result, approximately 5 million veterans have been provided with a Veterans Choice Card. Moreover, in connection with the VACAA modification, we operate a call center to assist veterans in determining their eligibility to use the card, and to help educate them on the VACAA. We also assist eligible veterans in obtaining an appointment with a community provider meeting VACAA requirements. We provide these services in the three PC3 regions in which we operate.

For the year ended December 31, 2014, revenues from the PC3 contract were approximately $24.7 million. For additional information on the risks associated with our PC3 contract, see “Item 1A. Risk Factors—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations*.”

Divested Operations and Services Segment

Prior to the first quarter of 2012, our Divested Operations and Services reportable segment included the operations of our businesses that provided administrative services to UnitedHealth Group and its affiliates in connection with the Northeast Sale, which was completed on December 11, 2009. For information about the Northeast Sale, see Note 3 to our consolidated financial statements included as part of this Annual Report on Form 10-K (our "consolidated financial statements").

Due to the sale of our Medicare stand-alone prescription drug plan business on April 1, 2012, starting with the first quarter of 2012, Divested Operations and Services reportable segment included transition-related revenues and expenses related to the sale of our Medicare PDP business to an affiliate of CVS Caremark.

As of December 31, 2012, we had substantially completed the administration and run-out of both of our divested businesses.

Provider Relationships

The following table sets forth the number of primary care physicians, specialist physicians and other health professionals contracted either directly with our HMOs or through our contracted participating physician groups ("PPGs") as of December 31, 2014. We have a number of physicians and other health professionals who are contracted providers for both HMOs and PPOs in our Western Region Operations, as follows:

Primary Care Physicians (includes both HMO and PPO physicians)	27,207
Specialist Physicians (includes both HMO and PPO physicians)	61,882
Health Professionals - Other (includes both HMO and PPO)	35,029
Total	124,118

Under our California HMO, EPO, HSP and POS plans, all members are required to select, or otherwise will be assigned to, a PPG and generally also a primary care physician from within the PPG. In our other plans, including all of our plans outside of California, members may be required to select a primary care physician from the broader HMO network panel of primary care physicians. The primary care physicians and PPGs assume overall responsibility for the care of members. Medical care provided directly by such physicians includes the treatment of illnesses not requiring referral, and may include physical examinations, routine immunizations, maternity and childcare, and other preventive health services. The primary care physicians and PPGs are responsible for making referrals (approved by the HMO's or PPG's medical director as required under the terms of our various plans and PPG contracts) to specialists and hospitals. Additionally, our tailored network products utilize a network that is smaller than our broader HMO network but contains a comprehensive array of physicians, specialists, hospitals and ancillary providers. Certain of our HMOs offer enrollees "open access" plans under which members are not required to secure prior authorization for access to network physicians in certain specialty areas, or "open panels" under which members may access any physician in the network, or network physicians in certain specialties, without first consulting their primary care physician.

PPG and physician contracts generally are for a period of at least one year and are automatically renewable unless terminated, with certain requirements for maintenance of good professional standing and compliance with our quality, utilization and administrative procedures. In California, PPGs generally receive a monthly capitation payment for every member assigned to it. The capitation payment represents payment in full for all medical and ancillary services specified in the provider agreements. For these capitation payment arrangements, in cases where the capitated PPG cannot provide the health care services needed, such PPGs generally contract with specialists and other ancillary service providers to furnish the requisite services under capitation agreements or negotiated fee schedules with specialists. Outside of California, most of our HMOs reimburse physicians according to a discounted fee-for-service schedule, although several have capitation arrangements with certain providers and provider groups in their market areas. A provider group's financial instability or failure to pay secondary providers for services rendered could lead secondary providers to demand payment from us, even though we have made our regular capitated payments to the provider group. Depending on state law and the regulatory environment, it may be necessary for us to pay such claims.

In our PPO plans, members are not required to select a primary care physician and generally do not require prior authorization for specialty care. For services provided under our PPO products and the out-of-network benefits of our POS products, we ordinarily reimburse physicians pursuant to discounted fee-for-service arrangements.

HNFS maintains a network of qualified physicians, facilities, and ancillary providers in the prime service areas of our T-3 contract for the TRICARE North Region. Services are provided on a fee-for-service basis. As of December 31, 2014, HNFS had 223,222 physicians, 3,862 facilities and 20,693 ancillary providers in its TRICARE network. HNFS also maintains a provider network comprised of approximately 49,270 providers in Regions 1, 2, and 4 in support of VA's PC3 program.

Our behavioral health subsidiary, MHN, maintains a provider network comprised of approximately 58,811 psychiatrists, psychologists and other clinical categories of providers nationwide. Substantially all of these providers are contracted with MHN on an individual or small practice group basis and are paid on a discounted fee-for-service basis. Members who wish to access certain behavioral health services contact MHN and are referred to contracted providers for evaluation or treatment services. If a member needs inpatient services, MHN maintains a network of approximately 1,384 facilities.

In addition to the physicians that are in our networks, we have also entered into agreements with various third parties that have networks of physicians contracted to them ("Third Party Networks"). In general, under a Third Party Network arrangement, Health Net is licensed by the third party to access its network providers and pay the claims of these physicians pursuant to the pricing terms of their contracts with the Third Party Network.

Hospital Relationships

Our health plan subsidiaries arrange for hospital care primarily through contracts with selected hospitals in their service areas. These hospital contracts generally have multi-year terms or annual terms with automatic renewals and provide for payments on a variety of bases, including capitation, per diem rates, case rates and discounted fee-for-service schedules.

Covered hospital-based care for our members is comprehensive. It includes the services of hospital-based physicians, nurses and other hospital personnel, room and board, intensive care, laboratory and x-ray services, diagnostic imaging and generally all other services normally provided by acute-care hospitals. Our nurses and medical directors are involved in a wide variety of medical management activities on behalf of our HMO and, to a somewhat lesser extent, PPO members. These activities can include discharge planning and case management, which often involves the coordination of community support services, including visiting nurses, physical therapy, durable medical equipment and home intravenous therapy.

Ancillary and Other Provider Relationships

Our health plan subsidiaries arrange for ancillary and other provider services, such as ambulance, laboratory, radiology, home health, chiropractic, acupuncture and other various therapy providers primarily through contracts with selected providers in their service areas. These contracts generally have multi-year terms or annual terms with automatic renewals and provide for payments on a variety of bases, including capitation, per diem rates, case rates and discounted fee-for-service schedules. In certain cases, these provider services are included in contracts our health plan subsidiaries have with PPGs and hospitals.

See “Item 1A. Risk Factors—*If we fail to develop and maintain satisfactory relationships on competitive terms with the hospitals, provider groups and other providers that provide services to our members, our profitability could be adversely affected*” for additional information on the risks associated with our provider relationships.

Additional Information Concerning Our Business

Competition

We operate in a highly competitive environment in an industry currently subject to ongoing significant changes resulting from the ACA, business consolidations, new strategic alliances, market pressures, and regulatory and legislative reform including but not limited to the federal health care reform legislation described below in “—Government Regulation”. Our primary competitors include managed health care companies, insurance companies, HMOs, third party administrators, self-funded groups and provider owned plans. Our health plans face substantial competition from both for-profit and nonprofit health plans that offer HMO, PPO, self-funded and traditional indemnity insurance products (including self-insured employers and union trust funds). We also face substantial competition from both for-profit and nonprofit health plans, as well as other non-health plan companies with respect to our contracts with state and federal government agencies, including our T-3, MFLC and PC3 contracts with the federal government, as well as our Medicaid and dual eligibles contracts, each of which may be subject to periodic re-competition. Some of our competitors have substantially larger enrollment and greater financial resources than we do. We believe that the principal competitive features affecting our ability to retain and increase membership include the range and prices of benefit plans offered, size and quality of provider network, quality of service, responsiveness to customer demands, financial stability, comprehensiveness of coverage, diversity of product offerings, market presence and reputation. The relative importance of each of these factors and the identity of our key competitors varies by market and product. We believe that we compete effectively against other health care industry participants.

Our primary commercial and Medicare competitors in California are Kaiser Permanente, Anthem Blue Cross of California, Blue Shield of California, and United/PacifiCare. Together, these four plans and Health Net account for approximately 82% of the insured commercial and Medicare market in California. Based on the number of 2014 enrollees, Kaiser is the largest managed health care company in California and Anthem Blue Cross of California is the largest PPO provider in California. In addition, two of the major national managed care companies, Aetna, Inc. and CIGNA Corp., are active in California, with a significant share of the self-insured market.

In Arizona, our primary commercial and Medicare competitors are BlueCross BlueShield of Arizona, Aetna, Inc., Cigna Corp., UnitedHealth Group, Inc., Anthem, Inc. and Humana, Inc.

In the California and Arizona Medicaid markets, we compete for members with other entities that have been awarded Medicaid contracts in the same counties, and if an applicable Medicaid county or region is put up for bid, we generally compete for state Medicaid contracts with other managed health care companies, both for profit and not-for-profit.

Our Oregon health plan competes primarily with Regence Blue Cross Blue Shield of Oregon, Kaiser Permanente, Moda Health Plan, Inc., Providence Health Plan, and PacificSource Health Plans.

With respect to the T-3 contract for the TRICARE North Region, and our MFLC and PC3 contracts, our primary competitors in the bidding process include Humana, United HealthGroup, Inc., Aetna, Inc., Anthem, Inc., Magellan Health Services, ValueOptions, Inc. and TriWest Healthcare Alliance, among others.

If we fail to compete effectively to maintain or increase our market share, our results of operations, financial condition and cash flows could be materially adversely affected. For additional information on competitive conditions in our business, see “Item 1A. Risk Factors—*The markets in which we do business are highly competitive. If we do not design and price our product offerings competitively, our membership and profitability could decline*.”

Cognizant Transaction

On November 2, 2014, we entered into a Master Services Agreement (as subsequently amended and restated, the "Master Services Agreement") with Cognizant Healthcare Services, LLC, a wholly owned subsidiary of Cognizant Technology Solutions Corporation (collectively, "Cognizant"). Under the terms of the Master Services Agreement, Cognizant will, among other things, provide us with certain consulting, technology and administrative services in the following areas: claims management, membership and benefits configuration, customer contact center services, information technology, quality assurance, appeals and grievance services, and non-clinical medical management support (collectively, the "BP and IT Services"). We will retain responsibility for our security policies and regulatory oversight.

Concurrent with executing the Master Services Agreement, we entered into an asset purchase agreement with Cognizant (the "Asset Purchase Agreement"), through which Cognizant will purchase certain software assets and related intellectual property from us for $50 million. These assets will include one of our claims processing systems, which will be used to perform a portion of the BP and IT Services. See Note 3 to our consolidated financial statements under the heading “Assets Held for Sale” for additional information on the assets sold in this transaction.

The transaction, including the related asset purchase (the "Cognizant Transaction"), is expected to close in the first half of 2015, subject to the receipt of required regulatory approvals. We expect that certain of our employees will become employees of Cognizant or its subcontractors, and that certain positions will be eliminated, as part of the Cognizant Transaction.

The initial term of the Master Services Agreement is seven years, commencing on the later of (i) ten business days following final regulatory approval of the Cognizant Transaction, and (ii) March 1, 2015 (the "Commencement Date"). We have two options to extend the Master Services Agreement for one year each by giving notice to Cognizant no less than three months prior to the end of the then existing term.

We will pay Cognizant for the BP and IT Services through a combination of fixed and variable fees, with the variable fees fluctuating based on our actual need for such services. Based on the currently projected usage of BP and IT Services over the initial term of the Master Services Agreement, we expect to pay Cognizant approximately $2.8 billion, subject to price adjustments described in the Master Services Agreement. The Master Services Agreement is expected to generate approximately $150 million to $200 million in annual general and administrative and depreciation expense savings for us by 2017.

Some of the BP and IT Services will be provided on our premises, while other BP and IT Services will be performed at Cognizant facilities. Cognizant will provide us with transition services required to migrate those activities that will be performed at Cognizant facilities. The anticipated cost of such transition services is included in the expected cost of the BP and IT Services over the initial term described above.

To protect our expectations regarding Cognizant’s performance, the Master Services Agreement has minimum service levels that Cognizant must meet or exceed. Failure to meet these minimum service levels will result in service level credits to us as described in the Master Services Agreement.

We retain the right to terminate the Master Services Agreement, in whole or in part, for, among other things, cause, convenience (including prior to the Commencement Date), certain performance failures, failure to obtain regulatory approvals, changes in law, force majeure, a change in the control of either Cognizant or us, a termination of the associated Business Associate Agreement, an adverse change in Cognizant’s financial condition, if Cognizant becomes a competitor of ours or if damages paid by Cognizant to us pursuant to the Master Services Agreement exceed a certain level. If we terminate the Master Services Agreement prior to the Commencement Date, we shall pay

Cognizant a break-up fee of $10 million. If we terminate the Master Service Agreement following the Commencement Date for reasons other than cause, a termination of the associated Business Associate Agreement, a change in the control of Cognizant or Cognizant becoming a competitor of ours, we shall pay Cognizant termination fees calculated on a sliding scale that reduces over time and based on the applicable termination event, and such fees could be material. For example, the maximum termination fee payable by us pursuant to the Master Services Agreement is $300 million, which would be triggered in the event we terminated for convenience during the first year of the term of the Master Services Agreement. In addition, in the event we experience a change in control during the first year of the term of the Master Services Agreement, the maximum termination fee payable is $130 million, assuming that we (or our successor) elect to terminate the Master Services Agreement.

We also retain the right to obtain disengagement assistance from Cognizant to facilitate the transition of BP and IT Services from Cognizant, regardless of whether the Master Services Agreement expires or is terminated. We will pay for the disengagement assistance through a combination of pre-determined charges and hourly fees for services for which there is no pre-determined charge. In addition, in the event of termination or expiration of the Master Services Agreement, we also retain the right to license at fair market value the software platform utilized by Cognizant in the performance of the BP and IT Services.

Cognizant has in the past provided, and may provide in the future, services to us under separate agreements. Some of these historical services are included in the BP and IT Services that will be provided by Cognizant under the Master Services Agreement.

The Cognizant Transaction is subject to certain risks and uncertainties, including with respect to the receipt of required regulatory approvals, which are discussed in further detail in "Item 1A. Risk Factors."***Marketing and Sales***

We market our products and services to individuals and employer groups through internal sales staff, independent brokers, agents and consultants and through the Internet and the new ACA-mandated exchanges. For our group health business, we market our products and services utilizing a three-step process. We first market to potential employer groups, group insurance brokers and consultants. We then provide information directly to employees once the employer has selected our health coverage. Finally, we engage members and employers in marketing for member and group retention. For our large group business, in general, we solicit enrollees from the employee base directly during "open enrollment" periods when employees are permitted to change health care programs. We use a variety of techniques to attract new enrollees and retain existing members, which at times include, without limitation, direct mail, work day and health fair presentations and telemarketing. Similar methods are used by our Medicare business to market to eligible individuals. Our sales efforts are supported by our marketing division, which engages in product research and development, multicultural marketing, advertising and communications, and member education and retention programs. Several states in which we operate, including California and Arizona, have launched health insurance exchanges in response to the ACA. The establishment of the exchanges under the ACA created a new competitive insurance marketplace for individuals and small businesses. As these exchanges mature, we intend to refine and enhance our exchange related marketing strategies.

Premiums for each employer group are generally contracted on a yearly basis and are payable monthly. We consider numerous factors in setting our monthly premiums, including changes in benefit design to address employer group needs and anticipated health care utilization rates as forecast by us based on the demographic composition of, and our prior experience in, our service areas. Premiums are also affected by applicable state and federal law and regulations that may directly or indirectly affect premium setting including, for example, premium loads for ACA-related taxes and fees assessed to health plans. Also, for policy years beginning January 1, 2014 and beyond, the ACA does not allow rating based on claims experience for small group and individual business. See "Item 1A. Risk Factors—*We face competitive and regulatory pressure to contain premium prices. If the premiums we charge are insufficient to cover our health care costs, it could have a material adverse effect on our business, financial condition or results of operations*" for additional information on regulations and legislation impacting our premium setting. Mandated benefits (requiring the coverage of certain benefits as a matter of law, whether desired by the group or not) also impact premiums. For example, in California and elsewhere, the ACA has impacted the scope of "essential health benefits" that health plans are required to offer, and mental health parity laws have generally broadened mental health benefits under health insurance policies offered by us and other carriers.

The ACA eliminated medical underwriting for medical insurance coverage decisions, including with respect to preexisting conditions (known as "guaranteed issue"). For additional detail on these and other requirements of the ACA, as well as certain associated risks, see "—Government Regulation—Health Care Reform Legislation and Implementation" and "Item 1A. Risk Factors—*Federal health care reform legislation has had and will continue to have an adverse impact on the costs of operating our business and a failure to successfully execute our operational and* *strategic initiatives with respect thereto could adversely affect our business, cash flows, financial condition and results of operations*."

Information Technology

Our business depends significantly on effective and efficient information systems. The information gathered and processed by our information management systems assists us in, among other things, pricing our services, monitoring utilization and other cost factors, processing provider claims, billing our customers on a timely basis, identifying accounts for collection and detecting fraud, security threats and other risks. Our customers and providers also depend upon our information systems for membership verification, claims status and other information. We have many different information systems that support our various lines of business and we develop new systems as needed to keep pace with continuing changes in technology and to support our operational needs, including potential business expansions. These systems require the ongoing commitment of significant resources for continual maintenance, upgrading and enhancement to meet our operational needs, evolving industry and regulatory standards, compliance with legal requirements (such as the ACA and ICD-10 (as defined below) and changing customer preferences).

We have partnered with third parties to support our information technology systems and to help design, build, test, implement and maintain our information management systems, and in November 2014 we announced the Cognizant Transaction, which would significantly increase the scope of services provided to us by third parties, subject to regulatory approval of the transaction. For additional information on the Cognizant transaction, see "—Cognizant Transaction" and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." Our merger, acquisition and divestiture activity also requires transitions to or from, and the integration of, various information management systems within our overall enterprise architecture.

CMS recently adopted a new coding set for diagnoses, commonly referred to as ICD-10, which significantly expanded the number of codes utilized in claims processing. TheICD-10 coding set is currently required to be implemented by October 2015. We incurred significant expenses in 2014 to implement and support the ICD-10 coding set, and expect to incur incremental costs ahead of the required implementation date. In addition, our implementation and support of the requirements of the ACA and the CCI, including the dual eligibles demonstration, have required, and will continue to require the expenditure of significant resources as we continue to adapt to the changing guidance.

For additional information on our information technology and associated risks, see "Item 1A. Risk Factors—*We are subject to a number of risks in connection with our decision to enter into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities*," Item 1A. Risk Factors—*If we fail to effectively maintain our information management systems, it could adversely affect our business*," "Item 1A. Risk Factors—*We are subject to risks associated with outsourcing services and functions to third parties*" and "Item 1A. Risk Factors—*If we or our business associates that handle certain information on our behalf fail to comply with requirements relating to patient privacy and information security, among other things, our reputation and business operations could be materially adversely affected.*"

Medical Management

We believe that managing health care costs is an essential function for a managed care company. Among the medical management techniques we utilize to contain the growth of health care costs are pre-authorization or certification for certain outpatient services and inpatient hospitalizations and a concurrent review of active inpatient hospital stays and discharge planning. We believe that this authorization process, along with the inherent features of a capitation payment model, helps to reduce inappropriate use of medical resources and achieve efficiencies in referring cases to the most appropriate providers. We provide multiple models of care management and case management to our members, and also contract with third parties to manage certain conditions such as neonatal intensive care unit admissions and stays, as well as chronic conditions such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and congestive heart failure. These techniques are widely used in the managed care industry and are accepted practices in the medical profession.

Accreditation

We pursue accreditation for certain of our health plans from the National Committee for Quality Assurance ("NCQA") and URAC. NCQA and URAC are independent, non-profit organizations that review and accredit HMOs and other health care organizations. HMOs that apply for accreditation of particular product lines receive accreditation if they comply with review requirements and quality standards. The Medicare line of business of our California HMO has received NCQA accreditation with a score of "commendable." HN California's commercial HMO/POS, HNL's PPO and our Arizona HMO's commercial lines of business and HN California's Medi-Cal line of business received NCQA accreditation with a score of "accredited." Our MHN subsidiary has received a URAC accreditation status of "full" for both Health Utilization Management and Health Network, which is the highest status awarded by URAC.

Government Regulation

Our business is subject to comprehensive federal regulation and state regulation in the jurisdictions in which we do business. These laws and regulations govern how we conduct our businesses and result in additional requirements, restrictions and costs to us. Certain of these laws and regulations are discussed below.

New laws and regulations, or changes in the interpretation of existing laws and regulations, including as a result of changes in the political climate, could have an adverse effect on us. In the event we fail to comply with, or fail to respond quickly and appropriately to changes in, applicable law and regulations, our business, results of operations, financial condition and cash flows could be materially and adversely affected. For additional information, see "Item 1A. Risk Factors—*Our businesses are subject to laws and significant rules and regulations, which increases our cost of doing business and could impact our financial performance by restricting our ability to conduct business or adversely affecting our ability to grow our businesses*" and "Item 1A. Risk Factors—*Federal and state audits, reviews and investigations of us and our subsidiaries could have a material adverse effect on our operations, financial condition and cash flows*."

Health Care Reform Legislation and Implementation

The ACA transformed the U.S. health care system through a series of complex initiatives. While we have experienced significant growth in our revenues and membership in certain products as a result of the ACA, the measures initiated by the ACA and the associated preparation and implementation of these measures have had, and will continue to have an adverse impact on our revenues and the costs of operating our business and could materially adversely affect our business, cash flows, financial condition and results of operations. Due in part to the scope and complexity of these initiatives, as well as their ongoing implementation, the ultimate impact of the ACA on us remains difficult to predict.

- The ACA imposes significant fees, assessments and taxes on us and other health insurers, health plans and industry participants. Among others, the ACA imposes a significant non-deductible tax (technically called a "fee") on health insurers, effective for calendar years beginning after December 31, 2013. In 2014, this "health insurer fee" was assessed at a total of $8 billion nationwide. In 2015, it is expected to be assessed at a total of $11.3 billion nationwide in 2015 and will increase annually thereafter. The health insurer fee will be allocated pro rata amongst industry participants based on a ratio of net health insurance premiums written for the previous calendar year to total net premiums written for the U.S. health insurance industry, subject to certain exceptions and adjustments. In September 2014, we paid the federal government a lump sum of $141.4 million for our portion of the health insurer fee.
- The ACA also required the establishment of state-run or federally facilitated "exchanges" where individuals and small groups may purchase health coverage. We are participating as QHPs in the currently operating exchanges in California and Arizona. For further information on these exchanges, see the discussion above under the heading "—Segment Information—Western Region Operations Segment—Western Region Exchanges."
- The ACA also contains premium stabilization provisions designed to apportion risk amongst insurers. These stabilization provisions include a permanent risk adjustment provision applicable to the individual and small group markets that became effective at the beginning of 2014, which will effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against the consequences of adverse selection. Other premium stabilization provisions include the temporary reinsurance and risk corridors programs, which seek to ease the transition into the post-ACA market by helping to stabilize rates and protect against rate uncertainty in the initial years of the ACA. To adapt to this economic framework, we have dedicated significant resources and incurred significant general and administrative costs to implement numerous strategic and operational initiatives both within and outside the exchanges that, among other things, have required us to focus on and manage different populations of potential members than we have in the past. The final determination and settlement of amounts due or payable from these premium stabilization provisions will not occur until 2015, and there is no assurance that the strategy we have executed will be successful or that the investments we have made to incorporate these provisions will be profitable.
- The ACA allowed extended funds to those states that opted to expand Medicaid eligibility from a pool that included residents with incomes up to 100% of the federal poverty level ("FPL") to an expanded pool of

residents with incomes up to 133% of the FPL. Medicaid expansion has driven a significant increase in our Medicaid enrollment in 2014. For additional discussion of Medicaid expansion and our Medicaid program, see the discussion above under the heading "—Segment Information—Western Region Operations Segment—Medicaid and Related Products."

For further information on certain of the provisions above and how they have impacted our operations in 2014, see Note 2 to our consolidated financial statements under the heading "Accounting for Certain Provisions of the ACA" and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Western Region Operations Reportable Segment."

Other provisions of the ACA include, among other things:

- imposing an excise tax on high premium insurance policies;
- requiring premium rate reviews in certain lines of business;
- stipulating a minimum medical loss ratio (as adopted by the Secretary of HHS);
- limiting Medicare Advantage payment rates;
- increasing mandated "essential health benefits" in some lines of business;
- specifying certain actuarial value and cost-sharing requirements;
- eliminating medical underwriting for medical insurance coverage decisions, including "guaranteed availability" with respect to individual and group coverage;
- limiting the ability of health plans to vary premiums based on assessments of underlying risk in the individual and small group markets;
- increasing restrictions on rescinding coverage;
- prohibiting some annual and all lifetime limits on amounts paid on behalf of or to our members;
- limiting the tax-deductible amount of compensation paid to health insurance executives;
- requiring that most individuals obtain health care coverage or pay a penalty, commonly referred to as the "individual mandate";
- imposing a sales tax on medical device manufacturers; and
- increasing fees on pharmaceutical manufacturers.

The schedule for implementation of the provisions of the ACA generally varies from as early as enactment to as late as 2018. A number of potentially significant provisions of the ACA became effective January 1, 2014, including the health insurer fee, the operation of QHPs purchased through the exchanges, the premium stabilization provisions described above, the guaranteed availability requirement, Medicaid expansion and the individual mandate. Other provisions, such as the excise tax on certain high-premium insurance policies, and the employer mandate for certain small- and mid-size employers, will not take effect until a later date. However, some of these provisions have had an earlier impact on our operations, including in connection with the setting of our premium rates and general and administrative expenses incurred in preparation for the ACA as discussed above.

Certain legal and legislative challenges to the ACA remain including, but not limited to litigation in Arizona related to Medicaid expansion and a challenge to the validity of premium tax credits on federally-facilitated exchanges that is currently scheduled to be heard in the U.S. Supreme Court.

We and other health insurance companies face uncertainty and execution risk due to the multiple, complex ACA implementations that are required in abbreviated time frames in new markets. Additionally, in many cases, our operational and strategic initiatives must be implemented in evolving regulatory environments and without the benefit of established market data. In addition, the lack of operating experience in these new marketplaces for insurers and, in certain cases, providers and consumers, increases the likelihood of a dynamic marketplace that may require us to adjust our operating and strategic initiatives over time, and there is no assurance that insurers, including us, will be able to do so successfully. Our execution risk encapsulates, among other things, our simultaneous participation in the exchanges, Medicaid expansion and the CCI, as described under the heading "—Segment Information—Western Region Operations—California Coordinated Care Initiative" above. These initiatives require us to effectively incorporate new and expanded populations and, among other things, required us to effectively and efficiently restructure our provider network to, among other things, meet the ACA's dynamic environment. Any delay or failure by us to execute our operational and strategic initiatives with respect to health care reform or otherwise appropriately react to the legislation, implementing regulations, actions of our competitors and the changing marketplace could result in operational disruptions, disputes with our providers or members, increased exposure to litigation, regulatory issues, damage to our existing or potential member relationships or other adverse consequences.

Due to the magnitude, scope, complexity and remaining uncertainties of the ACA, including the continuing modification and interpretation of the ACA rules and the operational risks involved with simultaneous implementation of multiple initiatives in new markets without established market data, we cannot predict the ultimate impact on our business of future regulations and laws, including state laws, implementing the ACA. Depending in part on its ultimate requirements, the ACA could have a material adverse effect on our business, financial condition, cash flows and results of operations.

For additional discussions of risks and uncertainties related to the ACA, see "Item 1A. Risk Factors."

Other Federal Laws and Regulation

Medicare Legislation and Regulation. Comprehensive legislation, specifically Title XVIII of the Social Security Act of 1935, as amended, governs our Medicare program. In addition, our Medicare contracts are subject to regulation by CMS. CMS has the right to audit Medicare contractors and the health care providers and administrative contractors who provide certain services on their behalf to determine the quality of care being rendered and the degree of compliance with CMS' contracts and regulations.

See "—Segment Information—Western Region Operations—Medicare Products" for more information on our Medicare business and see "Item 1A. Risk Factors—*Federal and state audits, reviews and investigations of us and our subsidiaries could have a material adverse effect on our operations, financial condition and cash flows*" for a description of certain regulatory risks associated with our Medicare business.

Medicaid and Related Legislation. Federal law has also implemented other health programs that are partially funded by the federal government, such as the Medicaid program (known as Medi-Cal in California). Our Medicaid programs are regulated and administered in California by the DHCS and in Arizona by AHCCCS. Federal funding remains critical to the viability of these programs. Federal law permits the federal government to oversee and, in some cases, to enact, regulations and other requirements that must be followed by states with respect to these programs. Medicaid is administered at the federal level by CMS. The dual eligibles demonstrations under the CCI are regulated and administered in Los Angeles and San Diego counties by CMS and DHCS.

See the discussion above under the heading "*—Western Region Operations Segment—Medicaid Expansion and Recent State Legislation,*" "*—Western Region Operations Segment—California Coordinated Care Initiative,*" and "Item 1A. Risk Factors—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations.*"

Privacy Regulations. State, federal, and local laws and regulations govern the privacy and security of Protected Health Information ("PHI"), Personal Information ("PI"), and other categories of legally protected data that our businesses handle. Such laws and regulations include, but are not limited to: the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") along with implementing regulations for both (collectively, "HIPAA Rules"); the Federal Trade Commission Act; the privacy provisions in the federal Gramm-Leach-Bliley Financial Modernization Act of 1999 (the "Gramm-Leach-Bliley Act"); state privacy and security laws such as the California Confidentiality of Medical Information Act, the California Online Privacy Protection Act, and state laws that specifically regulate the use and disclosure of social security numbers; and state breach notification laws that require providing notification in the event of a breach of PI (such as Cal. Code § 1798.82). Privacy and security laws and regulations often change due to new or amended legislation, regulations or administrative interpretation. A variety of state and federal regulators enforce these laws, including but not limited to HHS, the Federal Trade Commission, state attorneys general, and other state regulators.

The HIPAA Rules impose privacy and security obligations regarding PHI on Covered Entities (which refers to certain health plans, health care clearinghouses and providers) including but not limited to:

- complying with various requirements and restrictions related to the use, storage and disclosure of PHI,
- implementing internal policies and procedures to maintain the privacy and security of PHI,

- entering into written agreements with those entities that provide services to or on behalf of a Covered Entity and use, disclose, transmit, or maintain PHI in connection with these services (known as "Business Associates"), and
- notifying individuals and regulatory authorities (and in some cases, the media) if PHI is compromised.

These regulations also establish significant criminal penalties and civil sanctions for non-compliance. These requirements have evolved over time through the enactment and subsequent implementation of the HITECH Act (which enhanced enforcement, set additional limitations on the use and disclosure of PHI, and imposed additional potential penalties for non-compliance) and the Genetic Information Nondiscrimination Act of 2008 ("GINA") (which clarified that genetic information is protected under the HIPAA Privacy Rule and prohibited most health plans from using or disclosing genetic information for underwriting purposes).

Most recently, on January 17, 2013, HHS issued a final rule ("Omnibus rule") that strengthened the privacy and security protections for PHI by modifying the HIPAA Privacy, Security, and Enforcement Rules and implementing statutory amendments required by the HITECH Act and GINA. For example, the Omnibus rule enhances an individual's privacy protections, provides individuals new rights with respect to their PHI, strengthens the government's ability to enforce the HIPAA Rules, sets limits on how information is used and disclosed for marketing and fundraising purposes, and prohibits the sale of an individuals' health information without their permission. In addition, the Omnibus rule expanded the definition of which entities must be classified as a Business Associate and imposed on Business Associates many of the same privacy and security standards for protecting PHI that apply to Covered Entities. The final Omnibus Rule was effective on March 26, 2013. See "Item 1A. Risk Factors—*We must comply with requirements relating to patient privacy and information security, including requiring through contract that business associates that handle certain information on our behalf comply with relevant privacy and security requirements, including, but not limited to HIPAA*" and "—*We must comply with requirements relating to patient privacy and information security, including requiring through contract that business associates that handle certain information on our behalf comply with relevant privacy and security requirements, including, but not limited to HIPAA*" for additional information about the risks related to privacy and security breaches.

The Gramm-Leach-Bliley Act generally requires insurers to provide customers with notice regarding how their personal health and financial information is used and, in certain circumstances, gives customers the opportunity to "opt out" of having their information shared with non-affiliated third parties. Like HIPAA, this law sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. In addition, we process and maintain personal card data, particularly in connection with our individual exchange business. As a result, we are subject to the requirements under the Payment Card Industry ("PCI") Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.
Other state and federal laws and regulations, including some of the laws noted above, impose similar privacy and security requirements as the HIPAA Rules and the Gramm-Leach-Bliley Act.

ERISA. Many employee benefit plans are governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Employment-sponsored health coverage generally is such an employee benefit plan. ERISA is administered and regulated, in large part, by the U.S. Department of Labor. ERISA contains disclosure requirements for documents that define benefits and coverage, among other requirements. ERISA also provides that, in certain instances, federal law will preempt state law in the regulation and governance of certain benefit plans and employer groups, including the availability of legal remedies under state law. Regulations established by the U.S. Department of Labor provide additional rules for claims payment and member appeals under health care plans governed by ERISA.

Other Federal Regulations. We must comply with, and are affected by, laws and regulations relating to the award, administration and performance of U.S. Government contracts. Government contract laws and regulations affect how we do business with our customers and, in some instances, impose added costs on our business. In addition, because of our activities to support our MFLC contract and certain outsourcing arrangements we have with third party vendors, for example, we are also subject to the U.S. Foreign Corrupt Practices Act ("FCPA") and similar worldwide anti-corruption laws, including the U.K. Bribery Act of 2010, which generally prohibit companies and their intermediaries from making improper payments to non-U.S. officials for the purpose of obtaining or retaining business. A violation of specific laws and regulations by us or our agents could result in, among other things, the imposition of fines and penalties on us, changes to our business practices, the termination of our contracts or debarment from bidding on contracts. See "—Segment Information—Government Contracts Segment—Other Department of Defense Contracts" for additional information on our MFLC contract and "Item 1A. Risk Factors—*We are subject to risks associated with outsourcing services and functions to third parties*" for additional information on our outsourcing activities.

State Laws and Regulations

Our Western Region Operations operating subsidiaries are subject to extensive state regulation. Set forth below are the principal regulatory agencies that govern these health plans and insurance companies.

Company	Regulatory Agency
Health Net of Arizona, Inc.	Arizona Department of Insurance
Health Net Access, Inc.	Arizona Health Care Cost Containment System
Health Net of California, Inc.	California Department of Managed Health Care
Health Net Community Solutions, Inc.	California Department of Health Care Services and California Department of Managed Health Care
Health Net Health Plan of Oregon, Inc.	Oregon Department of Consumer and Business Services and Washington State Office of the Insurance Commissioner
Health Net Life Insurance Company	California Department of Insurance generally, and the Department of Insurance of each state in which it does business
Managed Health Network	California Department of Managed Health Care

Insurance and HMO laws impose a number of financial requirements and restrictions on our regulated subsidiaries, which vary from state to state. They generally include certain minimum capital and deposit and/or reserve requirements, restrictions on dividends and other distributions to the parent corporations and affiliated corporations. See “Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Statutory Capital Requirements.” These financial requirements are subject to change, which may require us to commit additional capital to certain regulated subsidiaries or may limit our ability to move capital through dividends and other distributions. In addition, some state insurance laws require regulated companies to provide to the insurance regulator, upon request, a summary description of its enterprise risk management framework, to undertake an Own Risk and Solvency Assessment ("ORSA") and to provide information on the entity's capital and solvency position.

While there are state-by-state variations, HMO regulation generally is extremely comprehensive. Among the areas regulated by these HMO regulatory agencies are:

- Adequacy of financial resources, network of health care providers and administrative operations;
- Sales and enrollment requirements, disclosure documents and notice requirements;
- Product offerings, including the scope of mandatory benefits and required offerings of benefits that are optional coverages;
- Procedures for member grievance resolution and medical necessity determinations;
- Accessibility of providers, handling of provider claims (including out-of-network claims) and adherence to timely and accurate payment and appeal rules;
- Linguistic and cultural accessibility standards, governance requirements and reporting requirements; and
- Implementation of some provisions of the ACA.

PPO regulation also varies by state, and while these regulations generally cover all or most of the subject areas referred to above, the regulation of PPO products and carriers tends to be less intensive than regulation of HMOs.

Variations in state regulation also arise in connection with the intensity of government oversight. Variations include: the need to file or have affirmatively approved certain proposals before use or implementation by the health plan; the degree of review and comment by the regulatory agency; the amount and type of reporting by the health plan to the regulatory agency; the extent and frequency of audit or other examination; and the authority and extent of investigative activity, enforcement action, corrective action authority, and penalties and fines. In addition, as discussed in further detail above under the heading “—Health Care Reform Legislation and Implementation,” the ACA required the establishment of health insurance exchanges that act as markets for the purchase of subsidized health insurance. States were given the option of establishing these exchanges on their own or allowing the federal government to fully or partially operate the exchange. We currently participate as QHPs in the exchanges in California, which elected to operate its own exchange, and Arizona, which elected the establishment of a federally-facilitated exchange. Participation in these and other exchanges in the states in which we operate is conditioned on the continued approval of the applicable state or federal government regulator. The factors considered for inclusion on the exchanges may be subject to additional changes in future years, which could impact some carriers' decision on participation in the exchanges.

State regulations also may be more stringent than federal regulations that are applicable to us, and various health insurance reform proposals have been implemented at the state level, including laws and regulations that implement portions of the ACA. The interaction of new federal regulations and the implementation efforts of the various states in which we do business will continue to create substantial uncertainty for us and other health insurance companies about the requirements under which we must operate. For additional information, see "—Segment Information—Government Regulation—Health Care Reform Legislation and Implementation."

Intellectual Property

We have registered and maintain various trademarks that we use in our businesses, including marks and names incorporating the "Health Net" phrase, and from time to time we apply for additional registrations of such marks. We utilize these and other marks and names in connection with the marketing and identification of products and services. We believe such marks and names are valuable and material to our marketing efforts.

Employees

As of December 31, 2014, Health Net, Inc. and its subsidiaries employed 7,922 persons on a full-time basis and 92 persons on a part-time or temporary basis. These employees perform a variety of functions, including, among other things, provision of administrative services for employers, providers and members; negotiation of agreements with physician groups, hospitals, pharmacies and other health care providers; handling of claims for payment of hospital and other services; and provision of data processing services. Our employees are not unionized and we have not experienced any work stoppages since our inception. We consider our relations with our employees to be very good.

Dependence Upon Customers

The federal government is the primary customer of our Government Contracts segment, with premiums and fees accounting for approximately 96% of our Government Contracts revenue and 4% of our total revenues in 2014. Premiums and fees from the federal government in connection with our TRICARE North Region contract accounted for 72%, 75% and 61% of our Government Contracts revenue in 2014, 2013 and 2012, respectively, and 3%, 4% and 4% of total revenues in 2014, 2013 and 2012, respectively. In addition, the federal government and the state of California are significant customers of our Western Region Operations segment as a result of our contract with CMS for coverage of Medicare-eligible individuals and our contracts with California state agencies for the federally-subsidized Medicaid program and the dual eligibles demonstration under the CCI. Medicare premiums accounted for 23%, 27% and 27% of our Western Region Operations segment health plan services premium revenues in 2014, 2013 and 2012, respectively, and 22%, 25% and 25% of our total revenues in 2014, 2013 and 2012, respectively. Medicaid premiums, including CHIP, accounted for 36%, 23% and 19% of our Western Region Operations segment health plan services premium revenues in 2014, 2013 and 2012, respectively, and 34%, 22% and 17% of our total revenues in 2014, 2013 and 2012, respectively. Dual eligibles premium revenues accounted for 1% of health plan services premiums and 1% of our total revenues in 2014. For a discussion of risks associated with our increasing dependence on government funded revenues, see "Item 1A. Risk Factors—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations.*"

Shareholder Rights Plan

On July 27, 2006, our Board of Directors adopted a shareholder rights plan pursuant to a Rights Agreement with Wells Fargo Bank, N.A. (the "Rights Agent"), dated as of July 27, 2006 (the "Rights Agreement").

In connection with the Rights Agreement, on July 27, 2006, our Board of Directors declared a dividend distribution of one right (a "Right") for each outstanding share of Common Stock to stockholders of record at the close of business on August 7, 2006 (the "Record Date"). Our Board of Directors 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 (as defined below) the redemption of the Rights and the expiration of the Rights and, in certain circumstances, after the Distribution Date. Subject to certain exceptions and adjustment as provided in the Rights Agreement, each Right entitles the registered holder to purchase from us one one-thousandth (1/1000th) of a share of Series A Junior Participating Preferred Stock, par value of $0.001 per share, at a purchase price of $170.00 (the "Purchase Price"). The terms of the Rights are set forth in the Rights Agreement.

Rights will attach to all Common Stock certificates representing shares outstanding and no separate certificates evidencing the Rights will be distributed. Subject to certain exceptions contained in the Rights Agreement, the Rights will separate from the Common Stock upon the earliest of (i) 10 days following the public announcement of any person, together with its affiliates and associates (an Acquiring Person), becoming the beneficial owner of 15% or more of the outstanding Common Stock, (ii) 10 business days following 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 Common Stock or (iii) 10 business days following the determination by our Board of Directors that a person, together with its affiliates and associates, has become the beneficial owner of 10% or more of the Common Stock and that such person is an “Adverse Person,” as defined in the Rights Agreement (the earliest of such dates being called the “Distribution Date”). The Rights Agreement provides that certain passive institutional investors that beneficially own less than 20% of the outstanding shares of the Common Stock shall not be deemed to be Acquiring Persons.

The Rights will first become exercisable on the Distribution Date and will expire at the close of business on July 31, 2016 unless such date is extended or the Rights are earlier redeemed or exchanged by us as described below.

Subject to certain exceptions contained in the Rights Agreement, in the event that any person shall become an Acquiring Person or be declared to be an Adverse Person, then the Rights will “flip-in” and entitle each holder of a Right, other than any Acquiring Person or Adverse Person and such person’s affiliates and associates, to purchase, upon exercise at the then-current exercise price of such Right, that number of shares of 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 we are acquired in a merger or other business combination in which the Common Stock does not remain outstanding or is changed or 50% of the assets, cash flow or earning power of the Company is sold or otherwise transferred to any other person, the Rights will “flip-over” and entitle each holder of a Right, other than an Acquiring Person or an Adverse Person and such person’s affiliates and associates, to purchase, upon exercise at the then current exercise price of such Right, such 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.

We may redeem the Rights at a price of $0.01 per Right at any time until the earlier of (i) 10 days following the date that any Acquiring Person becomes the beneficial owner of 15% or more of the outstanding Common Stock and (ii) the date the Rights expire. In addition, at any time after a person becomes an Acquiring Person or is determined to be an Adverse Person and prior to such person becoming (together with such person's affiliates and associates) the beneficial owner of 50% or more of the outstanding Common Stock, at the election of our Board of Directors, the outstanding Rights (other than those beneficially owned by an Acquiring Person, Adverse Person or an affiliate or associate of an Acquiring Person or Adverse Person) may be exchanged, in whole or in part, for shares of Common Stock, or shares of preferred stock of the Company having essentially the same value or economic rights as such shares.

Potential Acquisitions and Divestitures

We continue to evaluate the profitability realized or likely to be realized by our existing businesses and operations. From time to time we review, from a strategic standpoint, potential acquisitions and divestitures in light of our core businesses and growth strategies. See “Item 1A. Risk Factors—*Acquisitions, divestitures and other significant transactions may adversely affect our business*.”

Item 1A. Risk Factors

Cautionary Statements

The following discussion, as well as other portions of this Annual Report on Form 10-K, contain “forward-looking statements” within the meaning of Section 21E of the Exchange Act, and Section 27A of the Securities Act of 1933, as amended, regarding our business, financial condition and results of operations. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. These forward-looking statements involve a number of risks and uncertainties. All statements, other than statements of historical information provided or incorporated by reference herein, may be deemed to be forward-looking statements. Without limiting the foregoing, statements including the words “believes,” “anticipates,” “plans,” “expects,” “may,” “should,” “could,” “estimate,” “intend,” “feels,” “will,” “projects” and other similar expressions are intended to identify forward-looking statements. Actual results could differ materially from those expressed in, or implied or projected by the forward-looking information and statements due to, among other things, health care reform and other increased government participation in and taxation or regulation of health benefits and managed care operations, including but not limited to the implementation of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA") and related fees, assessments and taxes; our ability to successfully participate in California’s Coordinated Care Initiative, which is subject to a number of risks inherent in untested health care initiatives and requires us to adequately predict the costs of providing benefits to individuals that are generally among the most chronically ill within each of Medicare and Medi-Cal and implement delivery systems for benefits with which we have limited operating experience; our ability to successfully participate in the federal and state health insurance exchanges under the ACA, which involve uncertainties related to the mix and volume of business that could negatively impact the adequacy of our premium rates and may not be sufficiently offset by the risk apportionment provisions of the ACA; increasing health care costs, including but not limited to costs associated with the introduction of new treatments or therapies; our ability to reduce administrative expenses while maintaining targeted levels of service and operating performance, including through our master services agreement with a subsidiary of Cognizant; whether we receive required regulatory approvals for Cognizant’s provision of services to us and any conditions imposed in order to obtain such regulatory approvals; our ability to recognize the intended cost savings and other intended benefits of the Cognizant transaction; the risk that Cognizant may not perform contracted functions and services in a timely, satisfactory and compliant manner; negative prior period claims reserve developments; rate cuts and other risks and uncertainties affecting our Medicare or Medicaid businesses; trends in medical care ratios; membership declines or negative changes in our health care product mix; unexpected utilization patterns or unexpectedly severe or widespread illnesses; failure to effectively oversee our third-party vendors; noncompliance by our or our business associates with any privacy laws or any security breach involving the misappropriation, loss or other unauthorized use or disclosure of confidential information; the timing of collections on amounts receivable from state and federal governments and agencies; litigation costs; regulatory issues with federal and state agencies including, but not limited to, the California Department of Managed Health Care and Department of Health Care Services, the Arizona Health Care Cost Containment System, the Centers for Medicare & Medicaid Services, the Office of Civil Rights of the U.S. Department of Health and Human Services and state departments of insurance; operational issues; changes in economic or market conditions; investment portfolio impairment charges; volatility in the financial markets; and general business and market conditions.

Additional factors that could cause our actual results to differ materially from those reflected in forward-looking statements include, but are not limited to, the risks set forth below, and the other risks discussed in our other filings with the SEC.

Any or all forward-looking statements in this Annual Report on Form 10-K and in any other public filings or statements we make may turn out to be wrong. They can be affected by inaccurate assumptions we might make or by known or unknown risks and uncertainties. Many of the factors discussed below will be important in determining future results. These factors should be considered in conjunction with any discussion of operations or results by us or our representatives, including any forward-looking discussion, as well as information contained in press releases, presentations to securities analysts or investors or other communications by us. You should not place undue reliance on any forward-looking statements, which reflect management's analysis, judgment, belief or expectation only as of the date thereof and are subject to changes in circumstances and a number of risks and uncertainties. Except as may be required by law, we do not undertake to address or update forward-looking statements.

Federal health care reform legislation has had and will continue to have an adverse impact on the costs of operating our business and a failure to successfully execute our operational and strategic initiatives with respect thereto could adversely affect our business, cash flows, financial condition and results of operations.

The ACA transformed the U.S. health care system through a series of complex initiatives. While we have experienced significant growth in our revenues and membership in certain products as a result of the ACA, the measures initiated by the ACA and the associated preparation for and implementation of these measures have had, and will continue to have, an adverse impact on, among other things, the costs of operating our business, and could materially adversely affect our business, cash flows, financial condition and results of operations. Due in part to the magnitude, scope and complexity of these initiatives, as well as the continuing uncertainties related to their ongoing implementation and evolution, the ultimate impact of the ACA on us remains difficult to predict.

The ACA imposes significant fees, assessments and taxes on us and other health insurers, health plans and industry participants. Among others, the ACA imposes a significant non-deductible tax (technically called a “fee”) on health insurers, effective for calendar years beginning after December 31, 2013. In 2014, this “health insurer fee” was assessed at a total of $8 billion nationwide. In 2015, it is expected to be assessed at a total of $11.3 billion nationwide in 2015 and will increase annually thereafter. The health insurer fee will be allocated pro rata amongst industry participants based on a ratio of net health insurance premiums written for the previous calendar year to total net premiums written for the U.S. health insurance industry, subject to certain exceptions and adjustments. In September 2014, we paid the federal government a lump sum of $141.4 million for our portion of the health insurer fee based on 2013 net premiums written. We currently estimate that our allocable share of the health insurer fee payable in 2015, based upon 2014 premiums, will be approximately $230 million. However, this estimate is subject to inherent uncertainty as the amount of industry premiums upon which the fee allocation is based has not been announced and the Internal Revenue Service (“IRS”) is not expected to provide additional information on the 2014 health insurer fee until June 2015. While we are required to accrue for the health insurer fee on a pro rata basis throughout the year, in future years, we could experience significant volatility in our cash flow from operations relative to our results of operations in a given period because the health insurer fee is payable in a single lump sum based on prior year premiums. In 2014, due to the non-deductibility of the health insurer fee for federal income tax purposes, our full-year effective income tax rate was adversely affected by 24.8 percentage points. In future periods, we expect that the non-deductibility of the health insurer fee will continue to have a material impact on our effective income tax rate.

In addition, while certain types of entities and benefits are fully or partially exempt from the health insurer fee, including, among others, government entities, certain non-profit insurers and self-funded plans, we are unable to take advantage of any significant exemptions due to our current mix of plans and product offerings. Consequently, the health insurer fee has represented and will continue to represent a higher percentage of our premium revenues than those of our competitors who have business lines that are exempt from the health insurer fee or whose non-profit status may result in a reduced health insurer fee. Moreover, some of our competitors may have greater economies of scale or a different mix of business, which, among other things, may lead to lower expense ratios and higher profit margins than we have. Since the health insurer fee is not tax deductible and is based on net health insurance premiums written, rather than profits, it generally also will represent a higher percentage of our profits as compared to those competitors. We generally will be unable to match those competitors’ ability to support reduced premiums by virtue of making changes to distribution arrangements, decreasing spending on non-medical product features and services, or otherwise adjusting operating costs and reducing general and administrative expenses. As a result, the health insurer fee may adversely affect our profitability and ability to compete.

As a whole, the ACA’s fees, assessments and taxes will increase the costs of operating our business and could adversely affect our business, cash flows, financial condition and results of operations.

In addition, while the ACA does also present significant new business opportunities for us, we and other health insurance companies continue to face uncertainty and execution risk due to the multiple, complex ACA implementations that were and continue to be required in abbreviated time frames in new markets. Additionally, in many cases, our operational and strategic initiatives are being implemented in evolving regulatory environments and without the benefit of established market data. While we were able to implement several strategic and operational ACA initiatives during 2014, the relative lack of operating experience in these new marketplaces for insurers and, in certain cases, providers and consumers, has fostered a dynamic marketplace that requires us to continuously adjust our operating and strategic initiatives over time, particularly in these first few years of the ACA. There is no assurance that insurers, including us, will be able to successfully make these adjustments on an ongoing basis. Our execution risk encapsulates, among other things, our simultaneous participation in the exchanges, Medicaid expansion and California’s Coordinated Care Initiative (“CCI”), as further described in "Item 1. Business—Segment Information—Western Region Operations Segment—California Coordinated Care Initiative.” These initiatives involved the incorporation of new and expanded populations and, among other things, have required that we restructure our provider network in response, and will require us to remain diligent in monitoring the market to, among other things, effectively and efficiently adapt to the ACA’s dynamic environment. Any delay or failure by us to successfully execute our operational and strategic initiatives with respect to health care reform or otherwise appropriately react to changes to the legislation, implementing regulations, actions of our competitors and the changing marketplace could result in operational disruptions, disputes with our providers or members, increased exposure to litigation, regulatory issues, damage to our existing or potential member relationships or other adverse consequences that may have an adverse impact on our business, financial condition, cash flows and results of operations.

The ACA has been the subject of various legal challenges and legislative initiatives, which increase the uncertainty of how the law will impact us.

There are numerous steps required to implement the ACA, and although many significant regulations have been finalized, further amendments to these regulations, additional clarifying regulations and other guidance are expected over several years.

Even in cases where the federal government has issued final regulations, we and other health insurers continue to face uncertainty because these final regulations are sometimes unclear or incomplete, subject to further change, or rely on sub-regulatory guidance. For example, there is a potential for uncertainty and disruption related to an upcoming change in the definition of "small employer" for purposes of the types of plans that health insurance issuers can offer to employers. Currently, all of the states in which we operate regulate group health plans with 50 or fewer employees as small group plans. However, beginning in 2016, the ACA redefines the definition of small employer to include plans with up to 100 employees. Federal regulators have announced transitional guidance that will allow groups in the 51–100 size range to renew their current large group plans through plan years beginning on or before Oct. 1, 2016, but it is not clear whether the states in which we operate will adopt this transitional policy. Any uncertainty with regard to the change in definition or how the change will affect new and existing groups with 51-100 employees may lead to uncertainty in our ability to predict costs and set premiums in 2016 and future years.

In addition to ongoing regulatory questions, many of the operational components of health care reform are still being developed, including how market participants ultimately interact and adapt to the new requirements within and outside the ACA's state-run and federally-facilitated health insurance exchanges. Moreover, federal regulators have previously delayed implementation of certain ACA requirements through various extensions, allowances and transition periods, including the requirement that large employers provide coverage to full-time employees or pay a penalty, along with related reporting requirements, and the requirement that federal and state small business health option program exchanges be able to facilitate employee choice among multiple health plans, due to operational concerns impacting both employers and health insurance issuers. The markets impacted by these delays represent a significant portion of our business, including our small group markets, and as a result, we will be implementing certain key ACA related strategic and operational initiatives for the first time in 2015. These delays and developing regulations contribute to lingering uncertainty surrounding the ACA, and the ultimate impact of health care reform on us may not be evident until the ultimate requirements of the ACA have been definitively determined, the various related programs have been fully implemented, and both insurers and regulators are able to make necessary adjustments.

In addition, certain legal and legislative challenges to the ACA remain despite the U.S. Supreme Court's June 2012 decision in *NFIB v. Sebelius*. In *Sebelius*, the Supreme Court upheld the ACA's individual mandate as valid under Congress' taxing power. The *Sebelius* decision also permits states to opt out of the elements of the ACA that require expansion of Medicaid coverage in January 2014 without losing their existing federal Medicaid funding. Arizona and California have extended coverage to the uninsured through Medicaid expansions; however, the law in Arizona authorizing the expansion has been subject to litigation, and it is not clear when this will be resolved.

Several lawsuits have been brought regarding whether the ACA authorizes the IRS to provide premium tax credits (i.e., federal subsidies) to individuals who purchase coverage through a federally-facilitated exchange ("FFE"), and different federal courts have come to different conclusions on this matter. The U.S. Supreme Court has agreed to hear one of these challenges, *King v. Burwell*. Oral arguments are scheduled for March, 2015, although a final decision from the Supreme Court is not expected until as late as June, 2015. Any significant restriction or prohibition of federal subsidies for coverage obtained through FFEs may impact the affordability of FFE products for low income individuals, which in turn may have a material adverse impact on our FFE exchange membership in Arizona, and have an adverse impact on the Arizona individual market risk pool more generally. While such an outcome would most directly impact states with FFEs such as Arizona, the potential uncertainty created by such a ruling may have collateral effects in states with state-based exchanges or on the ACA in general, particularly in light of the newly Republican controlled Congress. For more information on our ACA health insurance exchanges, see the risk factor below under the heading, "—*We cannot assure you that our participation in the ACA's health insurance exchanges will continue to be a success*." Other litigation regarding the implementation of the ACA remains ongoing, including litigation around federal regulations regarding contraception coverage and regarding the ability of HHS to make payments to plans under the ACA's cost sharing reductions program.

On the legislative front, though repeal of the ACA in its entirety remains unlikely, Congress has proposed certain legislative initiatives that may affect certain provisions of the ACA, including initiatives that could repeal or modify the requirement that large employers provide coverage to employees, repeal the individual mandate, delay or repeal the tax on medical devices, delay or repeal the health insurer fee, repeal the risk corridors program and other potential changes.

Certain initiatives that have been unable to establish momentum in the past, may gain support with the newly Republican controlled Congress.

Certain of the proposed legislative changes described above, withholding of ACA funding by Congress, extended delays in the issuance of clarifying regulations and other guidance, delays in implementation, legal challenges or other lingering uncertainty regarding the ACA could cause us to incur additional costs of compliance or require us to significantly modify or adjust certain of the operational and strategic initiatives we have already established. Such modifications may result in the loss of some or all of the substantial resources that have been and will be invested in the ACA implementation, require investment of additional resources and, depending on the nature of the modification, could have a material adverse effect on our business and the trading price of our common stock.

Various health insurance reform proposals continue to emerge at the state level, which could have an adverse impact on us.

Various health insurance reform proposals have been considered at the state level, and more are likely to be considered in the future. Many of the states in which we operate have been implementing parts of the ACA and many states have added new requirements that are more exacting than the ACA's requirements. In most cases states can mandate minimum medical loss ratios("MLRs") , implement rate reforms and enact benefit mandates that go beyond provisions included in the ACA. For additional discussion on MLRs and its impact on our business, see "—*We face competitive and regulatory pressure to contain premium prices. If the premiums we charge are insufficient to cover our costs, it could have a material adverse effect on our business, financial condition or results of operations*." In addition, state exchange boards in California have the ability to limit the number of plans and negotiate the price of coverage sold on these exchanges and to limit the service areas in which Qualified Health Plans (“QHPs”) in the exchanges may operate. These kinds of state regulations and legislation could, among other things, limit or delay our ability to increase premiums in future years even where actuarially supported, and thereby could adversely impact our revenues and profitability. This also could increase the competition we face from companies that have lower health care or administrative costs than we do and therefore can price their premiums at lower levels than we can.

Further, the interaction of current and new federal regulations and the continuing implementation of federal health care reform by the various states in which we do business will continue to create substantial uncertainty for us and other health insurance companies about the requirements under which we must operate. States may disagree in their interpretations of the federal statute and regulations, and state “guidance” that is issued could be unclear or untimely. In the case of the ACA exchanges, we are required to operate under and comply with the regulatory authority of the federal government in addition to the laws, rules and regulations of each of the states that establish and administer their own exchanges. State exchange standards and processes related to areas such as enrollment, payment, certification standards, and other areas have differed and may differ in the future from those of the federally-facilitated exchanges. In some cases, it may not be clear whether federal or state guidelines apply, and federal and state guidelines may not align perfectly. For example, under current federal guidance, the determination of what constitutes a “small group” for purposes of determining whether a plan participates in the risk adjustment program may differ from the determination used by states in enforcing compliance with the market reform requirements for small group health plans in some instances. If we do not successfully implement the various state law requirements of the ACA, including with respect to the exchanges, our financial condition and results of operations may be adversely affected.

If we do not effectively incorporate the ACA’s premium stabilization and other related provisions into our business, or these provisions are not successful in mitigating our financial risks, our results of operations may be materially adversely affected.

The ACA also includes premium stabilization provisions designed to apportion risk amongst insurers, including the reinsurance, risk adjustment, and risk corridors programs.

The permanent risk adjustment program is applicable to plans in the individual and small group markets that are subject to the ACA’s market reforms. This risk adjustment program became effective at the beginning of 2014 and has and will continue to shape the economics of health care coverage both within and outside the exchanges. These provisions will effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against the consequences of adverse selection. The individual and small group markets represent a significant portion of our commercial business and the relevant amounts transferred may be substantial. To adapt to this new economic framework, we have dedicated significant resources and incurred significant costs to implement numerous strategic and operational initiatives both within and outside the exchanges that, among other things, require us to focus on and manage different populations of potential members than we have in the past.

The success of these initiatives relies on our ability to achieve an accurate risk adjustment allocation, which in turn depends in large part on our ability to accurately assess our health plans' risk and incorporate that into the risk adjustment calculus. This calculation relies primarily on encounter data to define a health plan's average actuarial risk. The process of accurately collecting this data presents disadvantages to more heavily capitated health plans such as ours because providers receiving fixed fees from health insurers may not have the same incentive to provide accurate and complete encounter data with respect to services rendered when compared to providers under fee for service arrangements. This incentive problem may be particularly acute for health plans operating under the delegated HMO model, which is prevalent in our California health plans. Under this model, third party intermediaries assume responsibility for certain utilization management and care coordination responsibilities, including the collection of encounter data. We have been refining our health plan infrastructure and provider network to help ensure that we are accurately capturing this data. However, if we are unable to successfully execute this strategy, our revenues and results of operations may be adversely affected. In addition, assuming we accurately capture complete encounter data, there is continued uncertainty about how HHS will validate this risk adjustment data. The "distributed data collection" approach by which HHS will collect risk adjustment data is still ongoing for 2014 plan data there remains some uncertainty regarding the types of penalties that will be imposed and the criteria for imposing such penalties where an insurer fails to provide sufficient data to HHS. Uncertainty or delay in the data collection process and the evaluation of preliminary risk scores in the context of our competitive market may limit our ability to accurately predict receivables or payables under the program and adversely impact our ability to set premium rates for future periods.

In addition to these permanent risk adjustment provisions, the ACA implements temporary reinsurance and risk corridors programs, which seek to ease the transition into the post-ACA market by helping to stabilize rates and protect against rate uncertainty in the initial years of the ACA.

We have made and are continuing to make significant efforts to design and implement a cohesive strategy with respect to these premium stabilization programs and the exchanges, but these programs are subject to risks inherent in estimated calculations and untested initiatives and the relevant regulatory framework for the ACA remains subject to change and interpretation over time. Calculating these premium stabilization provisions require us to estimate receivables and payables. Until the final calculations are performed that determine the amounts collectible and payable, the estimates can vary and the final amounts may materially differ from those estimates. The final determination and settlement of amounts due or payable from these premium stabilization provisions for 2014 will not occur until at least June 2015. If we are required to make material adjustments from our prior estimates, our financial condition, cash flows and results of operations could be materially adversely affected.

Many of the operational aspects relating to these premium stabilization programs, as well as related to advanced payments of premium tax credits for exchange plans, such as reporting data to HHS and the calculation of payments and charges, will be operationalized for the first time in 2015, including with respect to the small group market, and the data required and operational procedures for such reporting are still being developed. Any inability by Health Net to obtain and submit complete data for reporting under these premium stabilization or to reconcile our data with CMS or state exchanges as needed, could adversely affect our performance under these programs.

In addition, there have been recent legislative and regulatory developments with respect to the risk corridors program. In December of 2014, Congress passed and the President signed the Consolidated and Further Continuing Appropriations Act (Public Law 113-235), which contained language restricting the ability of HHS to use certain sources of funding to make payments under risk corridors program for 2015. HHS recognizes, in both final regulations and guidance, it is obligated to make the risk corridors program payments without regard to budget neutrality. Although HHS anticipates the program will be budget neutral, the ACA requires HHS to make full payments to those issuers with risk corridors ratios above 103 percent. Additionally, HHS states in final regulations and guidance that if the program's collections, including any potential carryover from prior years, are insufficient to satisfy its payment obligations, the agency will use other sources of funding to meet its payment obligations, subject to the availability of appropriations. If corridor collections are insufficient in 2014, HHS explains that it shall fulfill its obligations for the 2014 benefit year by using funds collected for the 2015 benefit year prior to making payments on 2015 obligations. The risk corridor receivable balance included in other noncurrent assets as of December 31, 2014 was $90.4 million and the risk corridor payable balance included in other noncurrent liabilities as of December 31, 2014 was $3.6 million. If we experience payment delays that are extended for any significant period of time, it may require us to modify our strategic and operational initiatives with respect to both our on and off exchange products, and could have a material adverse effect on our results of operations, financial position, cash flows or liquidity. For additional discussion of the risks associated with participation in programs involving a government payor, see the risk factor below under the heading, "—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs or if we do not effectively adapt to changes to these programs, we may experience a significant reduction in* *revenues from these government programs, which could have a material adverse effect on our business, financial condition or results of operations*."

Whether due to such regulatory uncertainty or otherwise, if these premium stabilization programs prove ineffective in mitigating our financial risks, including adverse selection risk, or we are unable to successfully adapt our strategy to any future changes in certain of our markets, our financial condition, cash flows and results of operations may be materially adversely affected. For additional information on these premium stabilization programs, see Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Health Care Reform Legislation and Implementation—Premium Stabilization Programs and Note 2 to our consolidated financial statements.

We cannot assure you that our participation in the ACA's health insurance exchanges will continue to be a success.

The ACA required the establishment of state-run or federally facilitated "exchanges" where individuals and small groups may purchase health coverage. We currently participate as QHPs in the exchanges in California and Arizona. Our continued participation in the exchanges and future participation in any other exchanges in the states in which we operate is conditioned on the approval of the applicable state or federal government regulator, which could result in the exclusion of some carriers, including us, from the exchanges.

We believe the exchanges have, and will continue to represent a significant commercial business opportunity for us. For example, our individual commercial enrollment increased nearly 190 percent during 2014, driven in large part by enrollment in the exchanges through the first open enrollment period. However, as we complete our second enrollment period, changing economic conditions, the dynamic competitive environment on the exchanges, various legislative and legal developments and the ongoing evolution of the regulatory framework for the exchanges may alter the economics and structure of our participation in the exchanges, which remain a new marketplace with which we have limited experience. If we are not able to successfully adapt to any such changes in our markets, our financial condition, cash flows and results of operations may be adversely affected. As an example, the size and mix of the exchange market pool is subject to change based on changes in the U.S. economy, changes to eligibility rules and processes and any changes to the validity of premium tax credits on FFEs. The exchange market pool is also impacted by changes in unemployment rates, average household income, and changes in employer coverage. In addition, the exchange market pool is impacted by the new processes for redetermination of eligibility based on income, employer coverage and eligibility management activities. These factors are generally beyond our control.

Furthermore, the complexity of the process may cause confusion for new consumers seeking to enroll for the first time as well as renewing consumers who may see changes in their plans and premium responsibility. In some cases, individuals have been terminated from exchange coverage or had their eligibility for subsidies adjusted or terminated due to a failure to provide documentation verifying eligibility, which results in additional administrative costs or membership losses for issuers. This complexity has required us to increase our consumer outreach and education efforts and modify our information systems to adapt to these new rules. In addition, while we have adapted our products and sales practices to the new direct-to-consumer channel opened by the exchanges, the exchanges have also required, and will continue to require, us to market to and administer premium collection through a new population with which we have limited experience. This new exchange population presents additional operational challenges, including the potential for discontinuance of coverage due to premium delinquency. Any failure to successfully implement these initiatives or modifications in response to developing regulations may have an adverse impact on our exchange membership and profitability on the exchanges.

Due to legislative developments and regulatory allowances designed to help smooth the transition into the ACA, there are a number of other aspects of the exchanges that have yet to be fully implemented or where there are still outstanding questions, including many of the primary functionalities of the SHOP plans, which were delayed until 2015, and certain aspects of the ACA's premium stabilization provisions. For additional information, see the risk factor above under the heading, "*—If we do not effectively incorporate the ACA's premium stabilization and other related provisions into our business, or these provisions are not successful in mitigating our financial risks, our results of operations may be materially adversely affected*." In addition, recent lawsuits filed by stakeholders on the exchanges have raised questions for exchange participants, including us, surrounding provider network size, network capacity and the adequacy of communication between health insurers and their consumers with respect to network composition for exchange products. In addition, state and federal regulators have expressed concern about provider network adequacy for exchange products. For example, the CDI recently issued an emergency regulation to establish stronger requirements for health insurers to create and maintain sufficient medical provider networks to provide timely access to medical care. In order to comply with the regulation, which was effective as of February 2, 2015, we and other health insurers will need to devote resources and incur significant costs. These and other similar actions by courts or regulators in this area may require us to adjust our tailored network exchange strategy or make other material modifications to our business and operations. Our exchange strategy relies heavily on our use of tailored network products and whether or not we are required to make adjustments to our networks, there is no assurance that our tailored network strategy will be successful over time. See “—*The markets in which we do business are highly competitive. If we do not design and price our product offerings competitively, our membership and profitability could decline*” for additional information regarding our tailored network strategy.

Our continued success on the exchanges is also dependent on our ability to respond to changes in the competitive market over time. The exchanges are an open market, with pricing and membership data publicly available to both consumers and our competitors. All exchange participants, including us, have reviewed our competitive positions, and with this data, our competitors could modify their product features or networks, change their pricing relative to others in the market and adjust their mix of business within or outside the exchanges. Competitors seeking to gain a foothold in the changing market may also introduce pricing that we may not be able to match, which may adversely affect our ability to compete effectively.

Taken together, the exchanges’ untested nature, the evolving marketplace surrounding them and the responses of state and federal decision makers to these issues have created lingering uncertainty for us and other health insurers participating in the exchanges. For example, on July 7, 2014, California Senate Bill 1446 (“SB 1446”) was signed into law effective immediately, allowing insurance carriers to continue non-grandfathered and non-ACA compliant small group policies that were in effect as of December 31, 2013 and active as of July 7, 2014 for one additional year through December 31, 2015. Arizona has similarly issued guidance allowing non-compliant plans to renew in some instances. While we expect that these transitional policies will help to reduce rate impact for many small groups that have not yet transitioned to ACA-compliant health plans, which in turn may help to reduce membership turnover in our small group business, these and similar allowances and extensions have demonstrated the ability of state and federal decision makers to revise the operational rules and regulations relating to the exchanges, in some cases with retroactive effect, in order to address future implementation or other difficulties. These types of delays or adjustments may in turn impact the economics of the exchange marketplace and the success of our strategy with respect to the exchanges. The resultant uncertainty extends to certain aspects of the exchanges that remain under consideration, including among other things, the premium stabilization provisions described in further detail herein. The fluid and novel nature of the exchange marketplace impacts our ability to predict exchange enrollment, premiums and costs, which may have an adverse effect on our revenues and results of operations. If we fail to effectively adapt our business strategy and operations to these evolving regulations and markets, our financial condition and results of operations may be adversely affected.

Our profitability will depend, in part, on our ability to accurately predict and control health care costs.

A substantial majority of the revenue we receive is used to pay the costs of health care services and supplies delivered to our members. Many of these costs, including costs associated with physician and hospital care, new medical technology and prescription drugs, for example, are rising. The total amount of health care costs we incur is affected by the number and type of individual services we provide and the cost of each service. Our future profitability will depend, in part, on our ability to accurately predict health care costs and to manage future health care utilization and costs through product pricing criteria, utilization management, product design, medical management initiatives and negotiation of favorable professional and hospital contracts. Periodic renegotiations of hospital and other provider contracts, coupled with continued consolidation of physician, hospital and other provider groups, may result in increased health care costs or limit our ability to negotiate favorable rates. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused, and are expected to continue to cause, the private sector to bear a greater share of increasing health care costs. Additionally, there is always the possibility that adverse risk selection could occur when members who utilize higher levels of health care services compared with the insured population as a whole choose to remain with our health plans rather than risk moving to another plan, or, in the case of the exchanges, that members who elect to purchase products through the exchange will utilize higher levels of health care services than those in off exchange products. Moreover, the introduction of new populations with which there is limited cost experience, including through Medicaid expansion, the exchanges and the CCI, as well as the uncertain impact of premium stabilization provisions on the industry could adversely affect our ability to accurately predict or control health care costs. Any of these factors could cause our health care costs to be higher than anticipated and therefore cause our financial results to fall short of expectations.

Other factors that may adversely affect our ability to predict and control health care costs and, as a result, adversely affect our financial condition, results of operations and cash flows include but are not limited to changes in utilization rates; demographic characteristics; catastrophes; large scale public health epidemics; terrorist activity; unanticipated seasonality; changes in provider reimbursement; fluctuations in medical cost trends; the regulatory environment, including, for example, the implementation of the ACA or other state or federal laws and their impact on our health care costs and our ability to change our premium rates; health care practices; the introduction of new therapies, treatments or drugs; inflation; new technologies; clusters of high-cost cases; and continued consolidation of physician, hospital and other provider groups. A significant category of our health care costs is the cost of hospital-based products and services. Factors underlying the increase in hospital costs include, but are not limited to, the underfunding of public programs, such as Medicaid and Medicare and the constant pressure that places on rates from commercial health plans, new technology, state initiated mandates, alleged abuse of hospital chargemasters, an aging population, changes in the economic environment and, under certain circumstances, relatively low levels of hospital competition caused by market concentration. Another significant category of our health care costs is costs of pharmaceutical products and services. Factors affecting our pharmaceutical costs include, but are not limited to, the price of drugs, utilization of new and existing drugs, changes in discounts and the impact of health care reform on pharmaceutical manufacturers through such requirements as increased fees. For example, drugs recently approved for the treatment of hepatitis C have been aggressively priced by pharmaceutical companies. Due to the relatively high incidence of hepatitis C in populations we serve and a number of factors that may drive significant demand for these therapies, these products may cause a significant increase in our health care costs and, if we are unable to effectively manage these costs, it may adversely affect our profitability and results of operations.

As a measure of the impact of medical costs on our financial results, relatively small differences between predicted and actual medical costs as a percentage of premium revenues can result in significant changes in our financial results. For example, if medical costs increased by 1% without a proportional change in related revenues for our health plan products, our annual pre-tax income for 2014 would have been reduced by approximately $113 million. The inability to accurately forecast and manage our health care costs in all circumstances could have a material adverse effect on our business, financial condition or results of operations.

We face competitive and regulatory pressure to contain premium prices. If the premiums we charge are insufficient to cover our costs, it could have a material adverse effect on our business, financial condition or results of operations.

In addition to the challenge of controlling health care costs, we face competitive pressure to contain premium prices. While health plans compete on the basis of many factors, including service, plan benefits and the quality and depth of provider networks, price has been and will continue to be a significant basis of competition. Any future increase in our premiums could result in the loss of members, particularly in light of continued economic pressures and the implementation of the ACA. Our premiums are set in advance of the actual delivery of services, and, in certain circumstances, before contracting with providers. While we attempt to take into account our estimate of expected health care and other costs over the premium period in setting the premiums we charge or bid, factors such as competition, new or changed regulations and other circumstances may limit our ability to fully base premiums on estimated costs. For example, certain of our competitors are not subject to the ACA's health insurer fee or are assessed at half the rate that we and other health insurers will pay, and our ability to incorporate the impact of the health insurer fee into our commercial and Medicare 2015 premium rates, which are set a year in advance in 2014, was limited, in large part due to these competitive pressures. In addition, many factors may, and often do, cause actual health care costs to exceed those costs estimated and reflected in premiums or bids. These factors include, but are not limited to, increased utilization rates, increasing medical cost trends, catastrophes, public health epidemics, terrorist activity, unanticipated seasonality, changes in insured population characteristics, new mandated benefits or other regulatory changes, including those included in the ACA or other state or federal laws. If we are unable to accurately estimate costs and set our premiums accordingly, it could have a material adverse effect on our business, financial condition or results of operations.

In addition, our ability to increase our premiums may be restricted by law. For example, the ACA requires the establishment of a process for review of certain premium rate increases to determine whether they are “unreasonable.” As part of this rate review process, certain insurers may be excluded from participating in the state-based or federally facilitated exchanges created by the ACA if the review determines that the insurer has demonstrated a pattern or practice of excessive or unjustified premium rate increases. The federal government and some states in which we do business have also required prior regulatory approval of premium rate increases and/or have subjected such increases to heightened scrutiny, such as third-party review. For example, the CDI and Department of Managed Health Care require a third-party actuarial review of health insurance carriers' and health plans' proposed premium rate increases to confirm compliance with applicable law, resulting in a potential delay in carriers' and plans' ability to implement rate increases. Further, in California, proponents of rate review qualified an initiative measure for the November 2014 ballot that would have, if approved, imposed significant additional requirements on health plans relating to premium increases. While the initiative was defeated, there can be no assurance that the California legislature will not consider similar rate regulation measures in the future. These requirements and proposed changes have in the past and could in the future, among other things, lower the amount of premium increases we receive or extend the amount of time that it takes for us to obtain regulatory approval to implement increases in our premium rates. In recent years, certain of our competitors were asked by the Commissioner of the CDI to voluntarily delay implementation of scheduled premium increases to permit additional review by the CDI, which review led the carriers to reduce proposed rate increases. We have experienced, and are likely to continue to experience, greater scrutiny by regulators of proposed increases to our premium rates. For additional detail on the impact of federal health care reform and potential additional changes in federal and state legislation and regulations on our ability to maintain or increase premium levels, see "*—Federal health care reform legislation has had and will continue to have an adverse impact on the costs of operating our business and a failure to successfully execute our operational and strategic initiatives with respect thereto could adversely affect our business, cash flows, financial condition and results of operations,*" "*—The ACA has been the subject of various legal challenges and legislative initiatives, which increase the uncertainty of how the law will impact us,*""*—Various health insurance reform proposals continue to emerge at the state level, which could have an adverse impact on us,*" "*—If we do not effectively incorporate the ACA's premium stabilization and other related provisions into our business, or these provisions are not successful in mitigating our financial risks, our results of operations may be materially adversely affected*," and "*—We cannot assure you that our participation in the ACA's health insurance exchanges will continue to be a success*" (collectively the "ACA Risk Factors"). Our financial condition or results of operations could be adversely affected by significant disparities between the premium increases of our health plans and those of our major competitors or by limitations on our ability to increase or maintain our premium levels.

The ACA and other federal and state legislation and regulations require a reconciliation of premiums based on a final assessment of the relative medical risk a health plan incurs in the individual and small group market. Since the risk value is based on a health plan's score relative to the industry and enrollment growth of new populations with limited cost experience under ACA, we may be required to accrue additional liabilities based on the risk profile of the overall population. In addition, the ACA requires us to maintain certain minimum medical loss ratios, or "MLRs". In the event we fail to maintain such minimum MLRs, we will be required to rebate ratable portions of our premiums to our customers annually. Certain state Medicaid programs, including with respect to the Medi-Cal expansion population, are imposing MLR requirements on Medicaid managed care organizations that generally require such plans to rebate ratable portions of their premiums to their state customers if they cannot demonstrate they have met the minimum MLRs. With respect to our Medi-Cal expansion population, this MLR requirement acts as a "corridor", with rebates paid to DHCS for MLRs under 85% and additional premium paid to us by DHCS if MLRs exceed 95%. Beginning in 2014, we have been required to incorporate the effect of the aforementioned premium stabilization provisions for individual and small group markets into our commercial MLRs. Due in part to the uncertainty with respect to these premium stabilization provisions, which as noted above will be calculated for the first time in the summer of 2015 for the 2014 benefit year, it may be difficult to accurately predict our commercial MLR rebates, which may cause meaningful disruptions in our market share and our results of operations, financial position and cash flows could be materially adversely affected. For further information on MLRs, see Note 2 to our consolidated financial statements, and for further information on premium stabilization provisions, see "*—If we do not effectively incorporate the ACA's premium stabilization and other related provisions into our business, or these provisions are not successful in mitigating our financial risks, our results of operations may be materially adversely affected.*"

The markets in which we do business are highly competitive. If we do not design and price our product offerings competitively, our membership and profitability could decline.

We are in a highly competitive industry that is currently subject to significant changes from, among other things, legislative reform, business consolidations and new strategic alliances. Many of our competitors may have certain characteristics, capabilities or resources, such as greater market share, greater economies of scale, superior provider and supplier arrangements and existing business relationships, which give them an advantage in competing with us. These competitors include HMOs, PPOs, self-funded employers, insurance companies, hospitals, health care facilities and other health care providers. In addition, other companies may enter our markets in the future.

The addition of new competitors in our industry can occur relatively easily and customers enjoy significant flexibility in moving between competitors. For example, the new developing marketplace created by the ACA's state-based and federally facilitated exchanges has and may continue to encourage new market participants and lead to increased competition in the individual and small group markets. There also is a risk that our customers may decide to perform for themselves functions or services currently provided by us, which could result in a decrease in our revenues. In addition, our providers and suppliers may decide to market products and services to our customers in competition with us.

In addition, in response to changes in the health care market, including those related to federal and state health care reform, our competitors have in the past and could in the future modify their product features or benefits, change their pricing relative to others in the market and adjust their mix of business within or outside the exchanges, or even exit segments of the market. We may not be able to match our competitors' ability to support reduced premiums by virtue of any full or partial exemptions from the fees and taxes imposed by the ACA, or by making changes to their distribution arrangements, decreasing spending on non-medical product features and services, or otherwise adjusting their operating costs and reducing general and administrative expenses. New competitors seeking to gain a foothold in the changing market may also introduce product offerings or pricing that we may not be able to match, which may adversely affect our ability to compete effectively. The response to the ACA over time by our existing competitors and related adjustments to their offerings, if any, could cause meaningful disruption in local health care markets in which we operate.

In addition, while certain types of entities and benefits are exempt from the calculation of the health insurer fee, including, among others, government entities, certain non-profit insurers and self-funded plans, we are unable to take advantage of any significant exemptions due to our current mix of plans and product lines. Consequently, the health insurer fee will represent a higher percentage of our premium revenues than those of certain of our competitors who are able to exempt all or a portion of their premium revenues from the health insurer fee allocation. Moreover, some of our competitors may have greater economies of scale or a different mix of business, which, among other things, may lead to lower expense ratios and higher profit margins than we have. For additional discussion of how the ACA continues to affect the competitive landscape in which we operate, see the ACA Risk Factors above.

In recent years, there has been significant merger and acquisition activity in our industry and in industries that act as our suppliers, such as the hospital, medical group, pharmaceutical and medical device industries. This activity may create stronger competitors and/or result in higher health care costs. Furthermore, since the adoption of the ACA, we have seen further provider consolidation, which in turn could make it more difficult for us to negotiate competitive rates. In addition, our contracts with government agencies, such as our Medicaid contracts, T-3 contract for the TRICARE North Region and MFLC contracts, are from time to time up for re-bid. If we were to lose any significant government contract to a competitor, or if we were to win the bid for such contract on less favorable terms, it could have an adverse effect on our profitability, financial condition and results of operations. See "—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs or if we do not effectively adapt to changes to these programs, we may experience a significant reduction in revenues from these government programs, which could have a material adverse effect on our business, financial condition or results of operations*" for more information regarding our government contracts. To the extent that there is strong competition or that competition intensifies in any market, our ability to retain or increase our number of customers, our revenue growth, our pricing flexibility, our control over medical cost trends and our marketing expenses may all be adversely affected.

Tailored network products are an important part of our business strategy. Recently we have seen aggressive pricing by our competitors on certain tailored network products, and we will need to continue developing innovative provider relationships to remain competitive. For example, we have been working to build alliances with provider groups and other stakeholders in the health care system through shared risk arrangements, including Accountable Care Organizations ("ACOs"), that have seen increasing support as state and federal governments and the health care industry seek to improve the quality of care while controlling the costs of such care. Cost conscious large group customers that have embraced tailored networks are important to our ability to maintain scale in tailored network products, and some of these customers, including certain Medicare customers, may demand that we provide ACO or similar arrangements to reduce costs, or may seek to join a private health insurance exchange to pool risk and lower costs. Our ability to successfully implement such arrangements or design products for the private exchanges may be necessary to remain competitive for these accounts. There can be no assurance that we will be able to successfully implement and maintain these strategic initiatives that are intended to position us for future profitable growth in the post-ACA marketplace; that the products we have designed in collaboration with certain providers will be successful or developed within the time periods expected; or that the products that we offer will be preferable to similar products of our competitors. The loss of large group customers in tailored networks may make it more difficult to efficiently execute our tailored network strategy, which could have a material adverse impact on our commercial business.

These tailored networks are based on provider networks that may not include all hospitals or medical professionals. We cannot control the capacity of these organizations to serve new membership coming from other health plans or as a result of the ACA. With the growth in tailored network offerings in the State of California, there has been increased scrutiny by regulators and consumer watchdog groups with respect to network adequacy. For example, recent regulatory action and class action lawsuits have raised concerns regarding provider network size, network capacity and the adequacy of communication between health insurers and their consumers with respect to network composition for exchange products. Such regulatory action and lawsuits may require us to make changes to our provider networks, which could result in higher costs, deterioration in our competitive position and in membership loss. Failure to successfully implement our tailored network strategy may have an adverse impact on our business, results of operations, financial condition and cash flows.

If we do not compete effectively in our markets, if we do not design and price our products appropriately and competitively, if we are unable to innovate and deliver products and services that demonstrate value to our customers, if we set rates too high or too low for highly competitive markets, if we lose membership in more profitable products while retaining or increasing membership in less profitable products, if we do not provide satisfactory service levels, if membership or demand for our services does not increase as we expect or if membership or demand for our services declines, it could have a material adverse effect on our business, financial condition and results of operations.

Our inability to estimate and maintain appropriate levels of reserves for claims may adversely affect our business, financial condition or results of operations.

Our reserves for claims are estimates of incurred costs based on a number of assumptions. An extensive degree of actuarial judgment is used in this estimation process and considerable variability is inherent in such estimates. The accuracy of these estimates also may be affected by external forces such as, for example, changes in medical claims submissions and payment patterns and medical cost trends. Included in the reserves for claims are estimates for the costs of services that have been incurred but not reported ("IBNR") and for claims received but not processed. Our methodology for calculating these estimates is consistently applied from period to period, and our IBNR best estimate is made on an accrual basis and adjusted in future periods as required. Any adjustments to the prior period IBNR best estimates are included in the current period. As additional information becomes known to us, we adjust our assumptions accordingly to change our estimate of IBNR. Given the uncertainties inherent in such estimates, the actual liability could differ materially from the amounts reserved. If such a revision in our estimates results in significant unfavorable development, it could adversely affect current period net income, profitability per enrolled member and, subsequently, our earnings per share in any particular quarter or annual period. Our stock price could also be negatively impacted. If our actual claims liability is lower than estimated, it could mean that we set premium prices too high, which could result in a loss of membership. For additional information regarding our methodology in establishing our reserves for claims and other settlements, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Critical Accounting Estimates".

Our businesses are subject to laws and significant rules and regulations, which increases our cost of doing business and could impact our financial performance by restricting our ability to conduct business or adversely affecting our ability to grow our businesses.

Our businesses are subject to extensive federal and state laws, rules, and regulations, including, but not limited to, financial requirements, licensing requirements, enrollment requirements and periodic examinations by governmental agencies. Our HMO and insurance subsidiaries are subject to regulations relating to cash reserves, minimum net worth, premium rates, approval of policy language and benefits, appeals and grievances with respect to benefit determinations, provider contracting, utilization management, issuance and termination of policies, claims payment practices and a wide variety of other regulations relating to the development and operation of health plans. These laws, rules, and regulations are generally intended to benefit and protect providers and health plan members rather than stockholders of managed health care companies such as Health Net. There can be no assurance that we will be able to continue to obtain or maintain required governmental approvals or licenses. The laws, rules, and regulations governing our business and interpretations of those laws, rules, and regulations are subject to frequent change, and there is no guarantee that legislative or regulatory changes will not have a material adverse effect on us. Broad latitude is given to the agencies administering these laws, rules, and regulations to interpret them and to impose substantial fines or restrict our ability to do business when they believe violations or failures to meet standards or requirements have occurred. Regulatory agencies, such as the California Department of Managed Health Care, the California Department of Health Care Services, the CDI, CMS, the U.S. Department of Health & Human Services' Office of Civil Rights and state departments of insurance, have the authority to impose substantial fines and/or penalties against us, require us to change how we do business and restrict our business activities. Certain of these agencies have done so in the past, and may impose substantial fines and/or penalties against us, require us to change how we do business and restrict our business activities in the future if they determine that we have not complied with applicable laws, rules, and regulations. Further, such fines, penalties and restrictions may be more severe in circumstances in which regulatory agencies determine that we have repeatedly failed to comply with applicable laws, rules or regulations. See "*—Federal and state audits, reviews and investigations of us and our subsidiaries could have a material adverse effect on our operations, financial* *condition and cash flows"* for further discussion on the impact of any fines, penalties or restrictions that may be imposed against us. As we have members in various states and are therefore subject to the regulatory oversight of multiple jurisdictions, we have been in the past, and could be in the future, subject to fines and/or penalties imposed by multiple regulatory agencies relating to the same incident. Existing or future laws, rules, and regulations, including the ACA and related health care reform initiatives could, among other things, force us to change how we do business and may restrict our revenue and/or enrollment growth, increase our health care and administrative costs, and/or increase our exposure to liability with respect to members, providers or others. See the ACA Risk Factors above. Further, we may be liable for violations of laws, rules and regulations by individual Health Net associates notwithstanding our internal policies and compliance programs. For example, see "—*If we or our business associates that handle certain information on our behalf fail to comply with requirements relating to patient privacy and information security, among other things, our reputation and business operations could be materially adversely affected.*"

As a federal and state government contractor, we are subject to U.S. and state government oversight. The government may investigate our business practices and audit our compliance with applicable rules and regulations. Depending on the results of those audits and investigations, the government could make claims against us. Under government procurement regulations and practices, a negative determination resulting from such claims could result in a contractor being fined, debarred and/or suspended from being able to bid on, or be awarded, new government contracts for a period of time. In addition, we are subject to state and federal false claims laws that generally prohibit the submission of false claims for reimbursement or payment to government agencies. We are also subject to the Foreign Corrupt Practices Act and similar worldwide anti-corruption laws, including the U.K. Bribery Act of 2010, which generally prohibit companies and their intermediaries from making improper payments to non-U.S. officials for the purpose of obtaining or retaining business. Courts have imposed substantial fines and penalties against companies found to have violated these laws. We are also exposed to other risks associated with U.S. and state government contracting, including but not limited to dependence upon Congressional or legislative appropriation and allotment of funds, the impact that delays in government payments could have on our operating cash flow, and the general ability of federal and/or state government to terminate contracts with it, in whole or in part, without prior notice, for convenience or for default based on performance. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenue or membership, increase costs or adversely affect our ability to bring new products to market as forecasted. See "—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs or if we do not effectively adapt to changes to these programs, we may experience a significant reduction in revenues from these government programs, which could have a material adverse effect on our business, financial condition or results of operations.*"

We are subject to a number of risks in connection with our decision to enter into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities.

On November 2, 2014, we entered into a master services agreement (as subsequently amended and restated, the "Cognizant MSA") with a subsidiary of Cognizant Technology Solutions Corporation, a Delaware corporation ("Cognizant") for the performance of a significant portion of our business process and information technology activities. As a result of the agreement, we anticipate a material reduction in our annual general and administrative and depreciation expense by 2017. However, the agreement is conditioned upon regulatory approval of the transaction, and there can be no assurance that such approval will be obtained in a timely manner or at all. Regulators may also require us to make changes to the current structure of the transaction (including, without limitation, the scope of services covered by the transaction) as a condition precedent to approval. If regulatory approval is not obtained, substantially delayed or conditioned on changes to the terms of the transaction being made, we may not be able to fully realize anticipated cost savings or other expected benefits of the transaction. We have incurred material costs and will continue to incur material incremental costs and devote substantial resources to prepare for the Cognizant transaction. If regulatory approval is not obtained or the Cognizant MSA is otherwise terminated prior to Cognizant's commencement of services, we will lose some or all of the resources that have been and will be invested in this transaction through such date, which could have a material adverse impact on our business.

The Cognizant MSA covers a broad range of consulting, technological and administrative services in claims management, membership and benefits configuration, customer contact center services, information technology, quality assurance, appeals and grievance services, and medical management support. We also expect that certain of our employees will become employees of Cognizant or its subcontractors, and that certain positions will be eliminated, as part of the transaction. Given the scope of services that will be provided by Cognizant, and assuming the transaction closes, the transition presents considerable execution risk inherent to large scale strategic and operational initiatives, including, among others, with respect to the efficient and secure transfer of information and data and the management of our workforce, which will require us to coordinate and monitor the transition through our dedicated governance and oversight structure.

The success of our business will depend in part on Cognizant's ability to perform the contracted functions and services in a timely, satisfactory, and compliant manner. If we experience a loss or disruption in the provision of any of these functions or services, or they are not performed in a timely, satisfactory or compliant manner, we may not fully achieve anticipated cost savings or other expected benefits of the transaction; we may be subject to regulatory enforcement actions; we may be vulnerable to security breaches that threaten the security and confidentiality of our information and data; we may not be able to meet the full demands of our customers or be subject to claims against us by our members; and we may have difficulty in finding alternate providers on terms favorable to us, or at all. Any of the foregoing could have an adverse impact on our business.

While the Cognizant MSA requires Cognizant to meet all regulatory compliance requirements with respect to the services provided, we ultimately retain responsibility for regulatory compliance. If we fail to adequately monitor and regulate Cognizant's performance throughout the term of the Cognizant MSA, we may be subject to additional risk. For additional information on these and other risks associated with third party arrangements such as the Cognizant transaction, please refer to the risk factors set forth below under the heading "*—We are subject to risks associated with outsourcing services and functions to third parties*" and "*—Federal and state audits, reviews and investigations of us and our subsidiaries could have a material adverse effect on our operations, financial condition and cash flows*."

Our participation in the dual eligibles demonstration portion of the California Coordinated Care Initiative in Los Angeles and San Diego Counties may prove to be unsuccessful for a number of reasons.

The CCI, and the dual eligibles demonstration program in particular, is a model of providing health care that is new to regulatory authorities and health plans in the State of California. Our participation and success in the dual eligibles demonstration is subject to a number of risks inherent in untested health care initiatives and new populations with limited cost experience. For example, the CCI requires us to provide benefits with which we had limited operating experience, including but not limited to LTSS benefits. Our failure to successfully organize and deliver on this model would negatively affect the operating and financial success of this business opportunity.

Some of the risks involved in the CCI and our participation in the dual eligibles demonstration include:

- Dual eligibles are generally among the most chronically ill individuals within each of Medicare and Medi-Cal, requiring a complex range of services from multiple providers. If we do not accurately predict the costs of providing benefits to dual eligibles or the rates under our agreement with CMS and DHCS prove to be inadequate, our participation in the CCI may prove to be unprofitable.
- Our profitability in the CCI will be dependent in part on our ability to successfully provide and administer LTSS benefits, both directly and through subcontracting arrangements with third parties. Because we have limited operating experience in providing and administering these benefits, particularly with respect to cost management, there is no assurance that the arrangements we have made and are continuing to refine will be on favorable terms or that the information exchange between us and these third parties will allow us to efficiently manage member care, which may adversely affect our results of operations, particularly as our Medi-Cal membership increases through, among other things, Medicaid expansion.
- Dual eligibles have the option to opt out of the dual eligibles demonstration while retaining all of their Medi-Cal benefits under CCI, including LTSS, which may reduce or eliminate the inherent efficiencies of the dual eligibles demonstration portion of the CCI. In particular, while the provision and administration of LTSS benefits may increase Medi-Cal costs, successfully managing care for these LTSS recipients may generate equal or greater Medicare savings in the form of reduced costs for treatment for acute conditions and/or hospitalizations. In the first year of the CCI, we experienced opt-out rates that were higher than originally anticipated. If large numbers of dual eligibles continue to opt out of the dual eligibles demonstration, we may be unable to capitalize on such potential efficiencies in the dual demonstration portion of the CCI, and, as a result, we may not be able to maximize our investment in the CCI and our profitability with respect to our participation in the CCI may be lower than originally anticipated.
- In each county, we will be offered as one of the health plans selected to participate in the CCI. Dual eligibles in each county will be able to select to receive benefits from any of the participating health plans. As a result of such competitive factors, we may not attract a satisfactory number of dual eligibles.

- We are required to make required filings with, and obtain approvals from, regulatory authorities in order to meet the ongoing demands of the CCI. There can be no assurance that we will obtain these approvals on satisfactory terms, or at all.
- We are subject to various other risks and uncertainties associated with participating in government programs such as Medicare and Medi-Cal. For example, the agreement we have with DHCS and CMS governing the dual eligibles demonstration may be terminated by DHCS and CMS without cause upon 180 days prior notice. Furthermore, the CCI itself is subject to changing legislation and regulations as well as state budgetary concerns. For example, the California Director of Finance is required to annually evaluate the CCI's cost effectiveness and report to the state legislature. If the legislature determines that the CCI is not cost effective, the program may be suspended. Furthermore, potential cost savings that were expected to improve the cost effectiveness of the program may be limited due to certain modifications imposed after the CCI became effective. These changes include the exemption of more than 100,000 potential beneficiaries from the dual eligibles demonstration based on their enrollment in Medicare D-SNP programs, their age or health condition, the transfer of significant savings initially allocated under the program from the state to the federal government, and the federal direction to suspend a tax that the state had used to fund the program implementation. The state has developed a new tax proposal that it believes complies with federal guidelines, but there is no assurance that it will successfully be enacted and approved. The 2015–16 California state budget projects net savings for the upcoming fiscal year, but also discusses potential risks, which, if not addressed by January 2016, could lead to the termination of the program in January 2017. See "*—Medicare programs represent a significant portion of our business and are subject to risk*", "*—Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs or if we do not effectively adapt to changes to these programs, we may experience a significant reduction in revenues from these government programs, which could have a material adverse effect on our business, financial condition or results of operations*" and "*—Federal and state audits, reviews and investigations of us and our subsidiaries could have a material adverse effect on our operations, financial condition and cash flows*".

Accordingly, there can be no assurance that the business opportunity presented by the CCI, including the dual eligibles demonstration, will prove to be successful. Our failure to successfully adapt to the requirements of the CCI, the inability of the program to generate the necessary cost savings for the state or the termination or suspension of the program by the state could have a adverse effect on our business, financial condition and results of operation, as well as the trading price of our common stock.

Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations.

Approximately 61% of our total revenues in the year ended December 31, 2014 relate to federal, state and local government health care coverage or counseling programs, such as Medicare, Medicaid, TRICARE and MFLC. Nearly all of the revenues in our Government Contracts reportable segment, which does not include Medicare and Medicaid related revenues, come from the federal government, either directly or as a sub-contractor for a federal government contract. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations" for more information regarding our reportable segments. In addition, a growing portion of our revenues for our Western Region Operations reportable segment, which includes Medicare and Medicaid related revenues, relates to government programs. Our Medicaid premium revenues for the year ended December 31, 2014 were approximately $4.8 billion, an increase of 95.7% from the prior year. The portion of our Western Region Operations reportable segment that relates to government programs is expected to increase in 2015 as, among other things, new members continue to enroll under both Medicaid expansion and the dual eligibles demonstration. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations—Western Region Operations Reportable Segment—California Coordinated Care Initiative" and "*—Our participation in the dual eligibles demonstration portion of the California Coordinated Care Initiative in Los Angeles and San Diego Counties may prove to be unsuccessful for a number of reasons*" for more information regarding our opportunities under the CCI and related risks. Due to this concentration of revenues, a significant reduction in revenues from the government programs in which we participate could have a material adverse effect on our business, financial condition or results of operations.

Our contracts with the government are generally subject to a highly-structured competitive bid process and government discretion in the negotiation process, including with respect to performance requirements. If we fail to design and maintain programs attractive to our government customers, if we are not successful in winning new contracts or contract renewals on favorable terms, or if our existing contracts are terminated, our current government health care coverage or counseling programs business and our ability to expand these businesses could be materially and adversely affected. Under government-funded health programs, the government payor typically determines premium and reimbursement levels and generally has the ability to terminate our contract for convenience. Any reduction in premium or reimbursement levels by the government payor, such as a reduction in Medicare Advantage payment rates as provided in the ACA, may lead to payment delay or result in premiums that increase at a lower rate than cost. If we are unable to make offsetting adjustments through supplemental premiums and changes in benefit plans, we could be adversely affected. In addition, the amount of government receivables set forth in our consolidated financial statements for our Government Contracts reportable segment represents our best estimate of the government's liability to us under TRICARE, MFLC, PC3 and other government contracts, or amounts due us as a sub-contractor. These government receivables are generally estimates subject to government audit and negotiation, and there is an inherent uncertainty in government contracts based in large part on a vulnerability to disagreements with the government. As a result, the final amounts we ultimately receive under government contracts for our Government Contracts reportable segment may be significantly greater or less than the amounts we initially recognize in our consolidated financial statements. Medicare revenue that we record may also be subject to change due to risk adjustment reimbursement settlements. See "—*Medicare programs represent a significant portion of our business and are subject to risk*" for additional information about risks related to these risk adjustment reimbursement settlements. Moreover, with respect to the ACA's premium stabilization provisions, the final determination and settlement of amounts due or payable relating to the 2014 calendar year will not occur until June 2015, which could have a material adverse impact on our cash flows and results of operations.

Contracts under our government programs are generally subject to frequent change, including but not limited to changes that may reduce the number of persons enrolled or eligible, expand or reduce the scope of the contract, reduce the revenue received by us or increase our administrative or health care costs, as applicable, under such programs. An enrollment freeze or significant reduction in payments from government programs in which we participate could adversely affect our business, financial condition or results of operations. Such changes may occur during re-competition of government contracts, for example. The T-3 contract for our TRICARE business expires on March 31, 2015. In June 2014, at the Department of Defense's request, we submitted a proposal to add three additional one-year options to our existing T-3 contract. The DoD has also informed us that it intends to complete its negotiations with us for the options prior to March 31, 2015, and that if such negotiations are successful, it intends to exercise the first of the one-year options by that date. However, there can be no assurance that we will finalize negotiations prior to March 31, 2015 or that we will do so at rates greater than or equal to those under the current T-3 contract. In the event the extension results in significantly reduced rates or if we are unable to finalize negotiations and our TRICARE business is opened up for rebidding and we are unable to secure a contract in the rebidding process, our results of operations could be adversely impacted. For additional information on our TRICARE operations, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Results of Operations—Government Contracts Reportable Segment."

In addition, the reimbursement rates we receive from federal and state governments relating to our government-funded health care coverage programs may be subject to change. For example, on April 1, 2014, CMS announced final 2015 Medicare Advantage benchmark payment rates for 2015 Medicare Advantage and Part D payments that we receive in connection with our participation in these programs. These payment rates represent reduced funding from the federal government compared to prior periods and adversely impacted our expected Medicare revenues for 2014. CMS announced proposed Medicare Advantage benchmark payment rates for 2016 on February 20, 2015, which set forth slight reductions to payment rates. Furthermore, if Medicare Advantage rates decline, our competitors may exit certain counties in which we participate, which may increase adverse selection risk and negatively impact our profitability. Any significant reduction in the reimbursement rates that we receive in connection with our government-funded health care coverage programs could adversely affect our business, financial condition or results of operations, particularly as our membership in and focus on government programs increases.

Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap. Certain other programs, including Medicaid benefits, are exempt from the sequestration cuts. All parts of the Medicare program, including Medicare Advantage, were subject to cuts, and these reductions have adversely impacted our Medicare Advantage MCR. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. In addition, legislation is currently being considered to repeal the "sustainable growth rate" formula that is used to calculate Medicare physician payments and replacing it with a new formula. While it is not currently clear what the details of any such legislation would be, such legislation, if finalized, could possibly make further cuts to Medicare payments or various related programs in order to offset the cost of the new payment formula.

Federal and state governments could also choose to require benefits to be delivered to new populations of potential members or require us to deliver new services to existing populations. If we have limited cost experience with these new populations or services, we may not be able to accurately predict or adequately control the associated health care costs. For example, as part of the CCI, we are required to expand our current Medi-Cal offerings to provide LTSS benefits to all our existing Medi-Cal members, including SPDs and those who do not participate in the dual eligibles demonstration portion of the CCI. We have limited operating experience in providing LTSS benefits, and if we are not able to successfully manage the associated costs, our financial condition and results of operations may be adversely affected.

In addition, our entrance into the Medicaid program in Arizona and Medicaid expansion in both California and Arizona have and will continue to significantly increase our Medicaid enrollment. This population of members may have different characteristics than our Medicaid population prior to Medicaid expansion. Moreover, both Medicaid expansion and the transition of individuals between the California individual exchange and Medi-Cal will result in changes to enrollment in both Medi-Cal and our exchange population, which will require us to maintain efficient information systems and coordinate efforts with multiple state and local agencies to help ensure that these individuals maintain continuous coverage. If we do not accurately predict the costs of providing benefits to these new populations, fail to obtain suitable rates or otherwise fail to efficiently and effectively incorporate these new and changing populations into our existing business, our results of operations, financial condition and cash flows could be adversely affected.

Finally, we are also exposed to other risks associated with U.S. and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state government to terminate contracts with it, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. For example, due to the federal government shutdown in October 2013, the Office of the Assistant Secretary of Defense, Health Affairs, Defense Health Agency delayed reimbursement payments owed to us for underwritten claims under the T-3 contract for our TRICARE business. These reimbursement payments were ultimately received following the conclusion of the government shutdown, and the delay did not have a material adverse effect on our results of operations or financial position. However, there can be no assurance that we will avoid similar payment delays in the future, which, if extended for any significant period of time, could have a material adverse effect on our results of operations, financial position, cash flows or liquidity. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenue or membership, increase costs or adversely affect our ability to bring new products to market as forecasted.

Other changes to our government programs could affect our willingness or ability to participate in these programs or otherwise have a material adverse effect on our business, financial condition or results of operations.

Medicare programs represent a significant portion of our business and are subject to risk.

Medicare programs represent a significant portion of our business, accounting for approximately 23% of our total premium revenue in our Western Region Operations reportable segment in 2014 and an expected 19% in 2015. The ACA includes, among other things, provisions that significantly reduce the government's Medicare payment rates. For more information on the risks associated with the ACA, see the ACA Risk Factors above. These ACA mandated reductions in Medicare payment rates have in the past and may continue in the future to have an adverse effect on our business, cash flows, financial condition and results of operations. For example, on February 20, 2015, CMS announced proposed Medicare Advantage benchmark payment rates for 2016, which reflected slight funding reductions from the prior year. In addition, all parts of the Medicare program, including Medicare Advantage, are subject to the risks of reduced government funding, including in connection with significant spending reductions in connection with the Budget Control Act of 2011. For additional detail on these cuts and the potential effect on our Medicare business, see "—*Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition* *or results of operations*." The cumulative impact of reductions in reimbursement rates, funding reductions and other factors has had an adverse impact on the profitability of our Medicare business in the past, and any further significant reductions in the reimbursement rates that we receive in connection with our Medicare business could adversely affect our business, financial condition or results of operations, particularly as our membership in and focus on government programs increases, including through the dual eligibles demonstration.

If we fail to design and maintain programs that are attractive to Medicare participants; if our Medicare operations are subject to sanctions or penalties; if we are not successful in winning contract renewals or new contracts; or if our existing contracts are terminated, our current Medicare business and our ability to expand our Medicare operations could be materially and adversely affected, negatively impacting our financial performance. There are also specific additional risks under Title XVIII, Part D of the Social Security Act associated with our provision of Medicare Part D prescription drug benefits as part of our Medicare Advantage plan offerings. These risks include potential uncollectibility of receivables, inadequacy of pricing assumptions, inability to receive and process information and increased pharmaceutical costs, as well as the underlying seasonality of this business, and extended settlement periods for claims submissions. Our failure to comply with Part D program requirements can result in financial and/or operational sanctions on our Part D products, as well as on our Medicare Advantage products that offer no prescription drug coverage.

In connection with our participation in the Medicare Advantage and Part D programs, we regularly record revenues associated with the risk adjustment reimbursement mechanism employed by CMS. This mechanism is designed to appropriately reimburse health plans for the relative health care cost risk of its Medicare enrollees. Under the CMS risk adjustment methodology, all Medicare Advantage plans must collect and submit diagnosis code data from hospitals and physician providers to CMS by specified deadlines. CMS uses this diagnosis information to calculate the risk adjusted premium paid to Medicare Advantage plans throughout the year. For any given year, the final settlement of these risk adjustment payments is generally made in the third quarter of the following year. Because the recorded revenue associated with the risk adjustment reimbursement mechanism is based on our best estimate at the time, the actual payment we receive from CMS for risk adjustment reimbursement settlements may be significantly greater or less than the amounts we initially recognize on our financial statements. See "*—Federal and state audits, reviews and investigations of us and our subsidiaries could have a material adverse effect on our operations, financial condition and cash flows"* for information on potential audits of the coding practices and provider documentation supporting the risk adjustment payments that we receive for our Medicare members.

In addition, CMS developed the Medicare Advantage Star Ratings system to help consumers choose among competing plans, awarding between one and five stars to Medicare Advantage plans based on performance on certain measures of quality. The Star Ratings are used by CMS to award quality bonus payments to Medicare Advantage plans. Beginning with the 2014 Star Rating, (calculated in the Fall of 2013), Medicare Advantage plans were required to achieve a minimum of 4 Stars to qualify for a quality bonus payment in 2015. The methodology and measures included in the Star Ratings system can be modified by CMS annually and Star Ratings thresholds are based on performance of Medicare Advantage plans nationally. For the 2015 Star rating (2016 payment year), our California HMO and Oregon HMO and PPO contracts with CMS were measured at 4.0 Stars. Our Arizona HMO contract was measured at 3.5 Stars and our California PPO contract was measured at 3.0 Stars in the Star Ratings system. This will place approximately 87% of our current membership in 4.0 Star plans for 2015 that qualify for an expected quality bonus payment in 2016. We are continuing to expand efforts and resources to improve our Star Ratings and other quality measures, but a failure to achieve a 4 Star Rating, and consequently failure to qualify for a quality bonus payment in any year, would have an adverse effect on our revenue, income and reputation, and could hinder our ability to compete effectively in the Medicare marketplace.

If we are unable to manage our general and administrative expenses, our business, financial condition or results of operations could be harmed.

The level of our administrative expenses can affect our profitability, and we may not be able to manage the level of our administrative expense in all circumstances. In addition, many of our competitors have substantially greater financial resources, higher revenues and greater economies of scale than we do, which among other things, may allow them to more successfully manage their general and administrative expense ratios or make investments in new technologies. While we attempt to effectively manage such expenses, including through the development of online functionalities and other projects designed to create administrative efficiencies, increases in staff-related and other administrative expenses may occur from time to time. These increases could be caused by any number of things, including difficulties or delays in projects designed to create administrative efficiencies, our entrance into new relationships with third parties, such as the arrangement we entered into with Cognizant in November 2014, acquisitions and divestitures, business or product start-ups or expansions, such as, for example, our participation in the CCI and the health insurance exchanges, changes in business or regulatory requirements, including compliance with the ACA, ICD-10 and HIPAA regulations, or other reasons. In addition, any failure to appropriately manage our general and administrative expenses could require us to increase premium rates in order to cover our health care costs and general and administrative expenses.

During recent years we have dedicated significant resources to implement programs designed to achieve general and administrative cost savings and improve our operational performance. As a part of these programs, we have and will continue to contract with key strategic partners in an effort to ultimately lower our cost structure and incremental costs and consolidate business and management operations, in particular the recent arrangement with Cognizant. Under this arrangement, Cognizant would perform a significant portion of our business process and information technology activities, subject to regulatory approval of the transaction. This transaction would significantly increase the scope of services currently performed for us by third parties. For additional details on the Cognizant transaction, see the risk factor under the heading "*—We are subject to a number of risks in connection with our decision to enter into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities*." However, there can be no assurance that our strategies to reduce our general and administrative costs and improve our operational performance will be successful or achieve anticipated savings.

In addition, in order to offset some of the reduced revenues from certain of our contracts, we continuously make efforts to reduce, reallocate or eliminate certain overhead and other administrative expenses. We cannot guarantee that we will be successful in making these cuts and adjustments at a pace that will maintain or increase our profitability.

Our business is regionally concentrated in the states of California, Arizona and Oregon.

Our business operations are primarily concentrated in three states: California, particularly Southern California, Arizona and Oregon. The majority of our Medicaid operations are in the state of California, with a high concentration of operations and members in Los Angeles County, and we now participate in the Medicaid program in Arizona. Medicaid expansion and our participation in the dual eligibles demonstration has further increased our concentration in Southern California, particularly Los Angeles County. Due to this geographic concentration, in particular in Southern California, we are exposed to the risk of a deterioration in our financial results if our health plans in these areas, in particular, Southern California, experience significant losses. In addition, our financial results could be adversely affected by economic conditions in these areas. If economic conditions in the state of California or in the other states in which we operate deteriorate, we may experience reductions in existing and new business, which could have a material adverse effect on our business, financial condition and results of operations. In addition, if reimbursement payments from a state are significantly delayed, our results of operations and cash flows could be adversely affected. For example, in the past, budget issues have led the state of California to delay certain of its monthly Medicaid payments to us. Any such irregularity in the timing of these payments in future periods may adversely impact our operating cash flow from quarter to quarter depending on the timing of such payments.

Federal and state audits, reviews and investigations of us and our subsidiaries could have a material adverse effect on our operations, financial condition and cash flows.

We have been and, in some cases, currently are, involved in various federal and state governmental audits, reviews and investigations. These include routine, regular and special investigations, audits and reviews by government agencies, state insurance and health and welfare departments and others pertaining to financial performance, market conduct and regulatory compliance issues. Such audits, reviews and investigations could result in the loss of licensure or the right to participate or enroll members in certain programs, or the imposition of civil or criminal fines, penalties and other sanctions, which could be substantial. In addition, disclosure of any adverse investigation, audit results, sanctions or penalties could negatively affect our reputation in various markets and make it more difficult or impossible for us to sell our products and services or negatively impact the trading price of our common stock. State attorneys general have become increasingly active in investigating the activities of health plans, and we have received in the past, and may continue to receive in the future, subpoenas and other requests for information as part of these investigations. We have, among other things, entered into consent agreements relating to, and in some instances have agreed to pay fines in connection with, several recent audits and investigations.

Many regulatory audits, reviews and investigations in recent years have focused on the timeliness and accuracy of claims payments by managed care companies and health insurers. Our subsidiaries have been the subject of audits, reviews and investigations of this nature. Depending on the circumstances and the specific matters reviewed, regulatory findings could require remediation of any claims payment errors and payment of penalties of material amounts that could have a material adverse effect on our results of operations.

We utilize claims submissions, medical records and other medical data as provided by health care providers as the basis for payment requests that we submit to CMS under the risk adjustment model for our Medicare Advantage contracts. CMS and the Office of Inspector General for HHS periodically perform risk adjustment data validation ("RADV") audits of selected Medicare health plans, including ours, to validate the coding practices of and supporting documentation maintained by health care providers. Our Arizona and California health plans have been selected for such an audit, though the results will not be known until CMS establishes a baseline "error rate." Such audits may result in retrospective adjustments to payments made to our health plans, fines, corrective action plans or other adverse action by CMS. In February 2012, CMS published a final RADV audit and payment adjustment methodology. The methodology contains provisions allowing retroactive contract level payment adjustments for the year audited, beginning with 2011 payments, using an extrapolation of the "error rate" identified in audit samples and, for Medicare Advantage plans, after considering a fee-for-service "error rate" adjuster that will be used in determining the payment adjustment. Depending on the error rate found in those audits, if any, potential payment adjustments could have a material adverse effect on our results of operations, financial position and cash flows.

We have been sanctioned in the past by CMS and have been advised that we will be subject to targeted monitoring and heightened surveillance and oversight by CMS going forward. Any future sanctions, fines or penalties against our Medicare operations may be more severe as a result of our past performance, particularly in circumstances in which CMS determines that we have repeatedly failed to comply with applicable laws, rules or regulations. If CMS were to impose financial or other penalties and/or sanctions on us, or terminate our existing Medicare contracts, this could have a material adverse effect on our Medicare business, our results of operations, cash flows or financial condition. See "—Medicare programs represent a significant portion of our business and are subject to risk" for additional information about our Medicare programs and the associated risks.

On February 4, 2015, we received a notice from the Arizona Health Care Cost Containment System ("AHCCCS"), Division of Health Care Management ("DHCM") that stated that we were in violation of its contract for Acute Care Medicaid services in Maricopa County. These violations for failure to meet contractual requirements included, among other things, deficiencies related to staffing and support services, website accessibility, provider credentialing, claims processing and grievance and appeals. As a result, DHCM imposed a monetary sanction of $200,000 to be withheld from our future capitation payments, and imposed a cap on auto assignment effective February 13, 2015 until further notice. DHCM also required us to submit corrective action plans as specified in the notice, and stated that any failure to correct the deficiencies outlined in the notice could result in additional compliance actions, including additional sanctions up to non-renewal of the one-year option to extend our Arizona Medicaid contract or termination of the contract in whole or in part. If we were to be subject to additional sanctions or if our contract with AHCCCS was terminated or not renewed, this could have an adverse impact on our Medicaid business, our reputation, results of operations, cash flows or financial condition.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. In addition, in November 2014 we announced that we entered into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities, subject to regulatory approval of the transaction. This transaction would significantly increase the scope of services currently performed for us by third parties. For additional details on the Cognizant transaction, see the risk factor under the heading "—*We are subject to a number of risks in connection with our decision to enter into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities*." Violations of, or noncompliance with, laws and/or regulations governing our business by such third parties, or governing our dealings with such parties, could, among other things, subject us to additional audits, reviews and investigations and adverse effects from such audits, reviews and investigations. In addition, from time to time, government agencies investigate whether our operations are being conducted in accordance with regulations applicable to government contractors, including but not limited to regular audits to enforce mandatory pricing arrangements. Government investigations of us, whether relating to government contracts or conducted for other reasons, could result in administrative, civil or criminal liabilities, including repayments, fines and/or penalties being imposed upon us, or could lead to suspension or debarment from government programs or future government contracting, which could have a material adverse effect on our financial condition, results of operations and cash flows. See "—*We are subject to risks associated with outsourcing services and functions to third parties*" for additional detail regarding risks associated with our relationships with third parties.

We face risks related to litigation, which, if resolved unfavorably, could result in substantial penalties and/or monetary damages, including punitive damages. In addition, we may incur material expenses in the defense of litigation and our financial condition, results of operations, cash flow and/or liquidity could be adversely affected if litigation expenses are greater than we project.

We have been in the past, are currently, or may become in the future, subject to a variety of legal actions, including but not limited to claims related to the insurance industry in general and our business in particular, such as claims by members alleging failure to pay for or provide health care, poor outcomes for care delivered or arranged, improper rescission, termination or non-renewal of coverage, and insufficient payments for out-of-network services. These legal actions also include claims brought against companies in general, including, but not limited to employment and employment discrimination-related suits, employee benefit claims, wage and hour claims, including, without limitation, cases involving allegations of misclassification of employees and/or failure to pay for off-the-clock work, breach of contract actions, tort claims, fraud and misrepresentation claims, shareholder suits, including, without limitation, suits alleging securities fraud, intellectual property and real estate related disputes, and claims arising from or in connection with acquisitions, divestitures and other significant transactions, including but not limited to actions to block or unwind such transactions. For example, we currently are a party to certain putative class and collective actions relating to the alleged misclassification of certain independent contractors under our MFLC program. See "Item 3. Legal Proceedings" for further information on this matter. In addition, we incur and likely will continue to incur potential liability for claims by employer groups for return of premiums; claims by providers, including claims for withheld or otherwise insufficient compensation or reimbursement, claims related to self-funded business and claims related to reinsurance matters; and claims alleging information security incidents and breaches. In our role as a federal and state government contractor, we are, and may be in the future, subject to qui tam litigation brought by individuals who seek to sue on behalf of the government for violations of, among other things, state and federal false claims laws. The legal actions to which we are currently and in the future could be subject can also include allegations of fraud, misrepresentation, breach of fiduciary duty, unfair or improper business practices and violations of state or federal antitrust laws and can include claims for punitive damages and various forms of injunctive relief. Also, there are currently, and may be in the future, attempts to bring class action lawsuits against various managed care organizations, including us. In some of the cases pending against us, substantial non-economic or punitive damages are also being sought.

We cannot predict the outcome of any lawsuit with certainty, and we have in the past and continue to incur significant expenses in the defense of litigation matters, including without limitation, substantial discovery costs. Recent court decisions and legislative activity may increase our exposure for any of the types of claims we face. There is a risk that we could incur substantial legal fees and expenses, including discovery expenses, in any of the actions we defend in excess of any amounts budgeted for defense. Plaintiffs' attorneys have increasingly used expansive electronic discovery requests as a litigation tactic. Responding to these requests, the scope of which may exceed the normal capacity of our historical systems for archiving and organizing electronic documents, may require application of significant resources and impose significant costs on us. In certain cases, we could also be subject to awards of substantial legal fees and costs to plaintiffs' counsel.

While we currently have insurance policies that may provide coverage for some of the potential liabilities relating to litigation matters, there can be no assurance that coverage will be available for any particular case or liability. Insurers could dispute coverage or the amount of insurance may not be sufficient to cover the damages awarded or settlement amounts. In addition, certain liabilities, such as punitive damages, may not be covered by insurance. Insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level that would result in us effectively self-insuring cases against us. The deductible on our errors and omissions ("E&O") insurance has reached such a level. Given the amount of the deductible, the only cases which would be covered by our E&O insurance are those involving claims that substantially exceed our average claim values and otherwise qualify for coverage under the terms of the insurance policy.

We regularly evaluate litigation matters pending against us, including those described in Note 13 to our consolidated financial statements included in this report, to determine if settlement of such matters would be in the best interests of the Company and its stockholders. We record reserves and accrue costs for certain significant legal proceedings which represent our best estimate of the probable loss, including related future legal costs, for such matters, both known and unknown. However, our recorded amounts might differ materially from the ultimate amount of any such costs. The costs associated with any settlement of or judgment relating to the various legal proceedings to which we are or may be subject from time to time, such as the proceedings described in Note 13, could be substantial and, in certain cases, could result in a significant earnings charge or impact on our cash flow in any particular quarter. The costs associated with any settlement of or judgment relating to the various legal proceedings to which we are or may be subject from time to time, such as the proceedings described in Note 13, could have a material adverse effect on our financial condition, results of operations, cash flow and/or liquidity and may affect our reputation.

We may not be able to manage our membership growth effectively.

We have experienced rapid growth in our membership as a result of the changing health care environment including the implementation of the exchanges, the CCI and Medicaid expansion in California and Arizona. We have devoted significant resources to manage this rapid growth in our membership, and continuing growth could significantly strain our management and other resources in the future. Our ability to continue managing membership growth effectively will depend, in part, on our ability to modify operational, financial and management information systems and functions on a timely basis and to attract, train, and retain skilled employees. In the event that we are unable to manage our membership growth effectively, this could have a material adverse effect on our business, financial condition, cash flows, or results of operations. See "*—We cannot assure you that our participation in the ACA's health insurance exchanges will continue to be a success," "—Our participation in the dual eligibles demonstration portion of the California Coordinated Care Initiative in Los Angeles and San Diego Counties may prove to be unsuccessful for a number of reasons,*" and "*—Government programs represent an increasing share of our revenues. If we are unable to effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations*"" for additional information. on the growth we have experienced in certain lines of business.

We are subject to risks associated with outsourcing services and functions to third parties.

We currently contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. These third parties provide a material amount of services to us, and include, but are not limited to, information technology infrastructure and applications solutions providers, medical management providers, claims administration providers, billing and enrollment providers, third party providers of actuarial services, call center providers and specialty service providers. In addition, in November 2014 we announced that we entered into a master services agreement with Cognizant for the performance of additional activities, including a significant portion of our business process and information technology activities, subject to regulatory approval of the transaction. For additional details on the Cognizant transaction, see the risk factor under the heading "*—We are subject to a number of risks in connection with our decision to enter into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities*." Our current and any future arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Any contractual remedies and/or indemnification obligations we may have for vendor or service provider failures may not be adequate to fully compensate us for any losses suffered as a result of any vendor's failure to satisfy its obligations to us or under applicable law. Our current and any future outsourcing arrangements could be adversely impacted by changes in the vendor's or service provider's operations, security posture or vulnerabilities, financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. If these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, may be required to pay a termination fee, which may be significant, and may incur significant costs and/or disruption to our operations in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition and results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays or difficulties in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems or disputes that could adversely impact our business, financial condition and results of operations.

Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. In addition, we currently outsource and may in the future outsource key services and functions to third parties, including companies doing business in foreign jurisdictions, which exposes us to risks inherent in conducting business outside of the United States, including international economic and political conditions, and additional costs associated with complying with foreign laws and U.S. laws applicable to operations in foreign jurisdictions, such as the Foreign Corrupt Practices Act and the U.K. Bribery Act of 2010.

We face a wide range of risks, and our success depends on our ability to identify, prioritize and appropriately manage our enterprise risk exposures.

As a large company operating in a complex and highly-regulated industry, we encounter a variety of risks. The risks we face include, among others, a range of strategic, regulatory, competitive, financial, operational, information technology, information security, reputational, external and industry risks identified in this Risk Factors discussion. The third party vendors and service providers to which we outsource key functions are required to achieve and maintain compliance with applicable federal and state laws and regulations and contractual requirements. Any violations of, or noncompliance with, laws and/or regulations governing our business, or the terms of our contracts, by third party vendors or service providers could increase our enterprise risk exposure. As we further outsource key functions, this risk increases. We continue to devote resources to further develop and integrate our enterprise-wide risk management processes. Failure to identify, prioritize and appropriately manage or mitigate these risks could adversely affect our profitability, our ability to retain or grow business or adversely affect our business, financial condition or results of operations.

If we fail to develop and maintain satisfactory relationships on competitive terms with the hospitals, provider groups and other providers that provide services to our members, our profitability could be adversely affected.

We contract with hospitals, provider groups and other providers as a means to provide access to health care services for our members, to manage health care costs and utilization and to help ensure the delivery of quality care. In any particular market, providers could refuse to contract with us, demand higher payments, or other contract terms that are unfavorable to us or take other actions, including litigation, which could result in higher health care costs, less desirable or uncompetitive products for customers and members, disruption to provider access or limited access for current members or to support growth, or difficulty in meeting regulatory or accreditation requirements. In some markets, certain providers, particularly hospitals, physician/hospital organizations and multi-specialty physician groups, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate contract terms that are unfavorable to us or otherwise place us at a competitive disadvantage, our ability to market our products or to be profitable in those areas could be adversely affected. The continuing trend of consolidation of hospitals, provider groups and other providers may further enhance this risk, particularly if such consolidation involves large high cost hospitals, providers or provider groups that we currently have under contract.

As the health care environment has evolved, we have developed and are continuously working to monitor strategic provider relationships with respect to the new market driven by, among other things, the ACA, the CCI and other federal and state health care reforms, regulations and initiatives. Accordingly, our business strategy includes creating tailored network products and other customized customer solutions through, among other things, strategic provider relationships that help manage the cost of care. For example, our product portfolios and services include offerings such as SmartCare℠, ExcelCare℠, PureCare℠ and CommunityCare℠, which are recent collaborations with our provider partners. Through these types of arrangements, we offer tailored network product offerings served by more cost-effective physician groups and hospitals. Membership in our tailored network products was approximately 50% of total commercial membership as of December 31, 2014, compared with approximately 38% as of December 31, 2013. For additional information on our tailored network products and innovative provider relationships, see “Item 1. Business—Segment Information—Western Region Operations Segment—Managed Health Care Operations.” The success of our tailored network products and continued development of strategic provider relationships are important parts of our business strategy. In addition, we will need to manage our provider network to support our participation in the CCI, including the provision of LTSS benefits for dual eligibles and other individuals, a service that we have not previously provided or managed. There can be no assurance that we will be able to successfully implement these strategic initiatives, that the products we design in collaboration with certain providers will be successful or developed within the time periods expected, or the products that we offer will be preferable to similar products of our competitors. Moreover, recent regulatory action and class action lawsuits have raised concerns regarding provider network size, network capacity and the adequacy of communication between health insurers and their consumers with respect to network composition for exchange products, which may require us to modify our tailored network strategy. See "*—The markets in which we do business are highly competitive. If we do not design and price our product offerings competitively, our membership and profitability could decline.*" Failure to successfully implement these strategic initiatives may have an adverse impact on our business, results of operations, financial condition and cash flows.

We contract with professional providers in California for HMO primarily through capitation fee arrangements. Generally, under a capitation fee arrangement, we pay a provider group a fixed amount per member per month and the provider group accepts the risk of the frequency and cost of member utilization of professional services, and in some cases, institutional services. Provider groups that enter into capitation fee arrangements generally contract with primary care physicians, specialists and other secondary providers to provide services. In addition, we frequently delegate responsibility for certain functions such as claims payment or utilization management to these providers under a "delegated HMO" model. The inability of provider groups to properly manage costs under capitation arrangements can result in their financial instability and the termination of their relationship with us. A provider group's financial instability or failure to pay specialists or secondary providers for services rendered could be exacerbated by the current economic conditions, and could lead specialists or secondary providers to demand payment from us, even though we have made our capitated payments to the provider group. We rely on our delegated, capitated physician groups to disburse this payment to their eligible providers, but in the event these groups fail to do so, we may find it necessary to pay such unpaid provider claims depending on state law, regulatory action or other factors. In California, for instance, although legal precedent to date has held that health plans generally are not liable for unpaid provider claims under these circumstances, there can be no assurance that the law will not change, or that we will not be found liable for unpaid provider claims in the future. There can also be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with specialists or secondary providers, the failure of any of which could have an adverse effect on the provision of services to members and our operations.

In addition, certain provisions of the ACA, including for example, the risk adjustment program, may make our existing provider fee arrangements less successful in certain of our market segments. The risk adjustment program defines a health plan's average actuarial risk and subsequently determines such health plan's risk adjustment payment allocation based on the collection of encounter data from providers. This structure puts more heavily capitated health plans such as ours at a disadvantage because providers receiving fixed fees from health insurers do not have the same incentive to provide accurate and complete encounter data with respect to services rendered when compared to providers under fee for service arrangements. This incentive problem is particularly acute under the delegated HMO model, which is prevalent in our California health plans. Under this model, third party intermediaries assume responsibility for certain utilization management and care coordination responsibilities, including the collection of encounter data. As a result, we have been working with providers to enhance our traditional capitation arrangements to help better align our and our providers' interests in capturing accurate and complete encounter data and determining an accurate average actuarial risk. For additional detail on the risk adjustment program and how the ACA and related proposals and initiatives are changing the health care landscape, see the ACA Risk Factors above. There can be no assurance that our efforts in this regard will be successful. Failure to successfully implement this strategy and receive accurate and complete encounter data may have an adverse impact on our results of operations, financial condition and cash flows.

Our dependence on capitated provider groups is substantial in our Western Region Operations reportable segment. Approximately 66% of our Western Region Operations members were enrolled with capitated provider groups as of December 31, 2014. Our use of tailored network products also places a greater emphasis on our relationships with certain capitated provider groups, as tailored network products restrict covered members' access to certain physician groups. If these capitated provider groups cannot provide comprehensive services to our members in tailored network products or encounter financial difficulties, it could have an adverse effect on the provision of services to members and our operations. In addition, the use of tailored network products could create an increased risk of out of network claims issues, which could result in higher medical costs to us.

The provider groups that we contract with are also required to achieve and maintain compliance with applicable federal and state laws and regulations. The inability of a provider group to pass compliance audits or otherwise maintain compliance with applicable laws and regulations may cause us to terminate a contract with a provider or assume responsibility for the noncompliant functions, such as claims payment or utilization management. Furthermore, violations of, or noncompliance with, applicable laws and/or regulations or contract terms by providers who perform delegated functions for us could increase our exposure to liability to our members or sanctions and/or fines from the regulators that oversee our business, among other things. We have seen increasing attention from regulators in this space, particularly with respect to provider network data integrity, and if we fail to adequately monitor and regulate the performance of these delegated entities, we could be subject to additional risk. For additional information, see "*—We are subject to risks associated with outsourcing services and functions to third parties*."

Some providers that render services to our members and insureds who have coverage for out-of-network services, or who obtain out-of-network emergency services, are not contracted with our plans and insurance companies. In certain cases, there is no pre-established understanding between the provider and the plan about the amount of compensation that is due to the provider; rather, the plan's obligation is to reimburse the provider based upon the terms of the member's plan or as otherwise required by law. The amount of provider reimbursement that a plan is obligated to pay in certain cases is established by a standard set forth in the plan that is not clearly translated into dollar terms, such as “maximum allowable amount” or “usual, customary and reasonable.” However, in other instances such reimbursement requirements are defined by statute or regulation and such amounts may, in certain instances, be greater than those calculated according to the plan standards. These statutory requirements related to provider reimbursements may increase our health care costs, which may adversely affect our business, financial condition or results of operations. In addition, providers who render out-of-network services may believe they are underpaid for their services and may either litigate or arbitrate their dispute with the plan or balance bill our member. Regulatory authorities in various states may also challenge the manner in which we reimburse members for services performed by non-contracted providers. As a result of litigation or regulatory activity, we may have to pay providers additional amounts or reimburse members for their out-of-pocket payments. The uncertainty about our financial obligations for such services and the possibility of subsequent adjustment of our original payments could have an adverse effect on our financial condition or results of operations.

Physicians and other professional providers, provider groups and hospitals that contract with us have in certain situations commenced litigation and/or arbitration proceedings against us to recover amounts for which they allege we are liable, including amounts related to unpaid claims and amounts they allege to be underpayments due to them under their contracts with us. We are currently a party to matters of this nature and could face additional claims or be subject to litigation and/or arbitration proceedings in the future in connection with similar matters. We believe that provider groups and hospitals have become increasingly sophisticated in their review of claim payments and contractual terms in an effort to maximize their payments from us and have increased their use of outside professionals, including accounting firms and attorneys, in these efforts. These efforts and the litigation and arbitration that result from them could have an adverse effect on our results of operations and financial condition.

Adverse general economic conditions could adversely affect our revenues and results of operations.

Adverse general economic conditions could expose us to a number of risks, including risks associated with the potential financial instability of our customers. In light of the substantial uncertainty surrounding the ultimate impact of the ACA and related state health care reform proposals, how the implementation of these new requirements will affect these risks remains unclear. If our customer base experiences cash flow problems or other financial difficulties, it could, in turn, adversely impact membership in our plans. For example, our customers could modify, delay or cancel plans to purchase our products, or may make changes in the mix of products purchased from us. If our customers experience financial issues, they may not be able to pay, or may delay payment of, accounts receivable that are owed to us. Further, our customers or potential customers may force us to compete more vigorously on factors such as price and service to retain or obtain their business, and in order to compete effectively in our markets, we also must deliver products and services that demonstrate value to our customers and that are designed and priced properly and competitively. A significant decline in membership in our plans and the inability of current and/or potential customers to pay their premiums as a result of unfavorable economic conditions, particularly our individual customers on the exchanges, could have a material adverse effect on our business, including our revenues, profitability and cash flow. In addition, a prolonged economic downturn could negatively impact the financial position of hospitals and other providers and, as a result, could adversely affect our contracted rates with such parties and increase our medical costs.

As of December 31, 2014, our Medi-Cal membership was approximately 1.6 million members, and it is expected to continue to increase in 2015 as a result of Medicaid expansion and our participation in the CCI. However, the State of California has experienced budget deficits in the recent past. Challenging economic conditions, another economic downturn or continued government efforts to contain medical costs and health care related expenditures could adversely affect state and federal budgets, including California's, resulting in reduced or delayed reimbursements or payments in our federal and state government-funded health care coverage programs, including Medicare and Medi-Cal or reimbursements or payments in these programs that do not keep pace with our cost trends. Any future state budget difficulties may also threaten the ongoing viability of the CCI, as discussed further in the risk factor under the heading, “*—Our participation in the dual eligibles demonstration portion of the California Coordinated Care Initiative in Los Angeles and San Diego Counties may prove to be unsuccessful for a number of reasons*.”

For additional discussion on budget issues at the federal level and the potential risks to our business, see the risk factor under the heading “*—Government programs represent an increasing share of our revenues. If we are unable to* *effectively administer these programs, if we do not effectively adapt to changes to these programs, or if we experience a significant reduction in revenues from these government programs, it could have a material adverse effect on our business, financial condition or results of operations*." In addition, continued state and federal budgetary pressures could cause new or higher levels of assessments or taxes for our commercial programs, such as surcharges on select fee-for-service and capitated medical claims or premium taxes on insurance companies and HMOs, and could adversely affect our results of operations. Moreover, any enrollment freeze or significant delay in reimbursement payment from government programs in which we participate could adversely affect our business, financial condition, cash flows and results of operations. For example, in the past, budget issues have led the State of California to delay certain of its monthly Medicaid payments to us. Any such irregularity in the timing of these payments in future periods may adversely impact our operating cash flow from quarter to quarter depending on the timing of such payments.

We must comply with requirements relating to patient privacy and information security, including requiring through contract that business associates that handle certain information on our behalf comply with relevant privacy and security requirements, including, but not limited to HIPAA.

We are subject to compliance obligations arising from laws and regulations governing certain Protected Health Information ("PHI") and Personal Information ("PI") including but not limited to: the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") and their respective implementing regulations; the Federal Trade Commission Act; federal regulations governing substance abuse records; state privacy and security laws such as the California Confidentiality of Medical Information Act ("CMIA") and the California Online Privacy Protection Act ("CalOPPA"); and state breach notification laws that require providing notification in the event of a breach of PI (such as Cal. Code § 1798.82). A variety of state and federal regulators enforce these laws, including, but not limited to HHS, the Federal Trade Commission ("FTC"), state attorneys general, and other state regulators. In addition, as our individual exchange business grows, we are increasingly impacted by requirements under the Payment Card Industry ("PCI") Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA regulations, as amended, require health plans, clearinghouses and providers to, among other obligations: comply with various requirements and restrictions related to the use, disclosure, storage, and transmission of PHI; adopt rigorous internal policies and procedures to safeguard PHI; and enter into specific written agreements with business associates that receive, transmit, use and/or create PHI on our behalf. HIPAA also established significant civil and criminal sanctions for violations. These regulations expose us to liability for, among other things, violations of the regulations by our business associates, including the third party vendors involved in our outsourcing projects. Other state and federal laws and regulations, including some of the laws noted above, impose similar privacy and security requirements.

The HITECH Act expanded HIPAA's requirements for security and privacy safeguards, including improved enforcement, additional limitations on use and disclosure of PHI and additional potential penalties for violations, and imposed notice obligations in the event of a breach of unsecured PHI.

The HITECH Act has been implemented on a rolling basis through subsequent rulemaking. On January 17, 2013, the Office of Civil Rights ("OCR") of HHS issued the omnibus final rule on HIPAA privacy, security, breach notification and enforcement requirements under the HITECH Act, and a final regulation for required changes to the HIPAA Privacy Rule for the Genetic Information Nondiscrimination Act. The omnibus final rule became effective on March 26, 2013, with an applicable compliance date of September 23, 2013. Although our contracts with our business associates require business associates to maintain the privacy and security of PHI and PI that we disclose to them, we may have limited control over the actions and practices of our business associates. This risk increases as we contract with third parties for the performance of additional services on our behalf. Compliance with HIPAA and state and federal privacy and security laws and regulations has resulted in and may in the future result in significant costs to us due to necessary systems changes, the development of new administrative processes and the effects of potential noncompliance by us or our business associates. If we or our business associates fail to comply with requirements relating to patient privacy and information security, such as applicable contractual requirements or the requirements imposed through the laws and regulations referenced above, our reputation and business operations could be materially adversely affected and our results of operation and financial condition could be adversely impacted.

If we or our business associates that handle certain information on our behalf fail to comply with requirements relating to patient privacy and information security, among other things, our reputation and business operations could be materially adversely affected.

The collection, maintenance, use, disclosure and disposal of individually identifiable information or data, including PHI and cardholder data, by our businesses are regulated at the federal and state levels, and in some cases are subject to contractual requirements. Despite the privacy and security measures we have in place to ensure compliance with applicable laws, regulations and contractual requirements, our facilities and systems, and those of our third party vendors and service providers, are vulnerable to privacy and security incidents including, but not limited to, computer hacking, breaches, acts of vandalism or theft, computer viruses or other forms of cyber-attack, misplaced or lost data, programming and/or human errors or other similar events. For additional details on the types of information we process and store, and the applicable laws, rules and regulations see the risk factor under the heading "—We must comply with requirements relating to patient privacy and information security, including requiring through contract that business associates that handle certain information on our behalf comply with relevant privacy and security requirements, including, but not limited to HIPAA."

A party, whether internal or external, that is able to circumvent our security systems could, among other things, misappropriate or misuse sensitive or confidential information (including but not limited to PHI, cardholder data and other member information), user information or other proprietary information, cause significant interruptions in our operations and cause all or portions of our website to be unavailable. Internal or external parties may attempt to circumvent our security systems, and we have in the past, and expect that we will in the future, experience external attacks on our network, such as, for example, reconnaissance probes, denial of service attempts, malicious software attacks and phishing attacks. We have expended significant resources to protect against such attacks, detect if and when attacks occur, respond to these attempted attacks and recover the enterprise to regular operations, and we expect to continue to do so in the future. Any reductions in the availability of our website could impair our ability to conduct our business and adversely impact our members during the occurrence of any such incident.

Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target and may originate from less regulated and remote areas around the world, we may be unable to proactively address all possible techniques or implement adequate preventive measures for all situations. Recent, well-publicized attacks on prominent companies, including in our industry, have resulted in the theft of significant amounts of sensitive and personal information and demonstrate the sophistication of the perpetrators and magnitude of the threat posed to companies across the nation, including the health care industry. In addition, in November 2014 we announced that we entered into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities, subject to regulatory approval of the transaction. The Cognizant transaction will require us to devote significant resources to transition from our existing systems infrastructure and relocate to a new data center, and if we are unable to successfully execute and manage this transition, the movement of data during the transition may enhance the information management and data security risks we currently face. For additional details on the Cognizant transaction and associated risks, see the risk factor under the heading "—*We are subject to a number of risks in connection with our decision to enter into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities*."

Noncompliance with any privacy laws or data security laws or any security incident or breach involving the misappropriation, loss or other unauthorized use or disclosure of sensitive or confidential member information, whether by us, one of our business associates or another third party, could have a material adverse effect on our business, reputation, financial condition and results of operations, including but not limited to: material fines and penalties; compensatory, special, punitive, and statutory damages; litigation; consent orders regarding our privacy and security practices; requirements that we provide notices, credit monitoring services and/or credit restoration services or other relevant services to impacted individuals; adverse actions against our licenses to do business; and injunctive relief. Additionally, the costs incurred to remediate any data security or privacy incident could be substantial.

If we fail to effectively maintain our information management systems, it could adversely affect our business.

Our business depends significantly on effective and efficient information systems. The information gathered and processed by our information management systems assists us in, among other things, pricing our services, monitoring utilization and other cost factors, processing provider claims, billing our customers on a timely basis and identifying accounts for collection. Our customers and providers also depend upon our information systems for membership verification, claims status and other information. We have different information systems for our various businesses and these systems require the commitment of significant resources for continual maintenance, upgrading and enhancement to meet our operational needs and evolving industry and regulatory standards. We have partnered with third parties to support our information technology systems and to help design, build, test, implement and maintain our information management systems. Additionally, in November 2014 we announced that we entered into a master services agreement with Cognizant for the performance of a significant portion of our information technology activities, which would significantly increase the scope of services provided to us by third parties in this regard, subject to regulatory approval of the transaction. Our merger, acquisition and divestiture activity also requires transitions to or from, and the integration of, various information management systems within our overall enterprise architecture.

We are in the process of reducing the number of systems that we operate. Any difficulty or unexpected delay associated with the transition to or from information systems, including in connection with the decommissioning of a system or the implementation of a new system; any inability or failure to properly maintain information management systems; any failure to efficiently and effectively consolidate our information systems, including to renew technology, maintain technology currency, keep pace with evolving industry standards or eliminate redundant or obsolete applications; or any inability or failure to successfully update or expand processing capability or develop new capabilities to meet our business needs, could result in operational disruptions, loss of existing customers, difficulty in attracting new customers, disputes with customers and providers, regulatory or other legal or compliance problems, significant increases in administrative expenses and/or other adverse consequences. If for any reason there is a business continuity interruption resulting in loss of access to or availability of data, we may, among other things, not be able to meet the full demands of our customers and, in turn, our business, results of operations, financial condition and cash flow could be adversely impacted. In addition, we currently obtain, and subject to regulatory approval, expect to obtain in the future, significant portions of our systems-related and other services and facilities, including our data center, from independent third parties. This makes our operations vulnerable to adverse effects if such third parties fail to perform adequately. See "—*We are subject to risks associated with outsourcing services and functions to third parties*."

In addition, the Cognizant transaction will require us to devote significant resources to transition from our existing systems infrastructure and relocate to a new data center, and if we are unable to successfully execute and manage this transition, the movement of data during the transition may enhance several of the information management and data security risks we currently face. For additional details on the Cognizant transaction and associated risks, see the risk factor under the heading "—*We are subject to a number of risks in connection with our decision to enter into a master services agreement with Cognizant for the performance of a significant portion of our business process and information technology activities*."

We also face challenges with respect to our implementation and support of the requirements of the ACA. Because federal and state regulators continue to release new and revised final rules and regulations relating to the implementation of the ACA, there remains substantial uncertainty with respect to these requirements, including, but not limited to rules and regulations related to the state-based and federally facilitated exchanges, the assessment and collection of the health insurer fee and the reinsurance, risk adjustment and risk corridors programs. Among other things, we have been required to define and implement new billing and payment capabilities and support new requests from third parties and government agencies for data collection and reporting. These additional demands have required and are continuing to require us to make significant systems changes, including developing, investing in, configuring, installing and monitoring the performance of new products and technology. The implementation of these changes has required and will continue to require the expenditure of material resources. See the ACA Risk Factors for further information regarding the ACA and the challenges we continue to face in implementing its provisions.

CMS adopted a new coding set for diagnoses, commonly referred to as ICD-10, which significantly expands the number of codes utilized. The new ICD-10 coding set is currently required to be implemented by October 2015. We will be required to incur additional expenses to implement and support the new ICD-10 coding set. If we have not adequately implemented the requirements of the ACA and ICD-10 within the time period required, our results of operations, financial condition and cash flows would be adversely affected.

As the requirements of supporting our businesses evolve over time, including as a result of the ACA's dynamic marketplace and in connection with the Cognizant transaction, there can be no assurances that we will be able to make the necessary systems changes or other modifications necessary to successfully meet such demands. If we do not successfully respond to such demands in a timely manner, our results of operations, financial condition and cash flows could be materially adversely affected.

We have a material amount of indebtedness and may incur additional indebtedness, or need to refinance existing indebtedness, in the future, which may adversely affect our operations.

Our indebtedness includes $400 million in aggregate principal amount of 6.375% Senior Notes due 2017. Our Senior Notes payable balance was $399.5 million as of December 31, 2014. In addition, we have a $600 million five-year revolving credit facility that expires in October 2016. As of December 31, 2014, we had $100.0 million outstanding under our revolving credit facility. For a description of our Senior Notes and our revolving credit facility, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Capital Structure." We may incur additional debt in the future. Our existing indebtedness, and any additional debt we incur in the future through drawings on our revolving credit facility or otherwise could have an adverse effect on our business and future operations. For example, it could:

- require us to dedicate a substantial portion of cash flow from operations to pay principal and interest on our debt, which would reduce funds available to fund stock repurchases, working capital, capital expenditures and other general operating requirements;
- increase our vulnerability to general adverse economic and industry conditions or a downturn in our business; and
- place us at a competitive disadvantage compared to our competitors that have less debt.

We continually evaluate options to refinance our outstanding indebtedness. Our ability to obtain any financing, whether through the issuance of new debt securities or otherwise, and the terms of any such financing are dependent on, among other things, our financial condition, financial market conditions within our industry and generally, credit ratings and numerous other factors. In the event we need to access the credit markets, including to refinance our debt, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time, if at all. If we are unable to obtain financing on terms and within a time acceptable to us it could, in addition to other negative effects, have a material adverse effect on our operations, financial condition, ability to compete or ability to comply with regulatory requirements.

Downgrades in our debt ratings may adversely affect our business, financial condition and results of operations.

Claims paying ability, financial strength, and debt ratings by nationally recognized ratings agencies are increasingly important factors in establishing the competitive position of insurance companies and managed care companies. We believe our claims paying ability and financial strength ratings also are important factors in marketing our products to certain of our customers. In addition, our debt ratings impact both the cost and availability of future borrowings and, accordingly, our cost of capital. Rating agencies review our ratings periodically and there can be no assurance that our current ratings will be maintained in the future. Our ratings reflect each rating agency's independent opinion of our financial strength, operating performance, ability to meet our debt obligations or obligations to policyholders and other factors, and are subject to change. Potential downgrades from ratings agencies, should they occur, may adversely affect our business, financial condition and results of operations.

We are a holding company and substantially all of our cash flow is generated by our subsidiaries. Our regulated subsidiaries are subject to restrictions on the payment of dividends and maintenance of minimum levels of capital.

As a holding company, our subsidiaries conduct substantially all of our consolidated operations and own substantially all of our consolidated assets. Consequently, our cash flow and our ability to pay our debt depends, in part, on the amount of cash that we receive from our subsidiaries. Our subsidiaries' ability to make any payments to us will depend on their earnings, business and tax considerations, legal and regulatory restrictions and economic conditions. Under California's Health Care Service Plan Act of 1975, as amended (also known as the Knox-Keene Act), our subsidiaries that are licensed under the Knox-Keene Act must comply with certain minimum capital or tangible net equity ("TNE") requirements ranging up to 130% of a specified minimum TNE for larger and older licensees such as Health Net of California. In addition, each of our subsidiaries regulated under the Knox-Keene Act have agreed to certain undertakings to the Department of Managed Health Care, restricting dividends and loans to affiliates, to the extent that the payment of such would reduce its TNE below 130% of the minimum requirement. In addition, in certain states our regulated subsidiaries are subject to risk-based capital requirements, known as RBC. These laws require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance in their state of domicile and the National Association of Insurance Commissioners. Failure to maintain the minimum RBC standards could subject certain of our regulated subsidiaries to corrective action, including increased reporting and/or state supervision. In addition, in most states, we are required to seek prior approval before we transfer money or pay dividends from our regulated subsidiaries that exceed specified amounts as determined by the state's formula. If our regulated subsidiaries are restricted from paying us dividends or otherwise making cash transfers to us, it could have material adverse effect on our results of operations and free cash flow. For additional information regarding our regulated subsidiaries' statutory capital requirements, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Statutory Capital Requirements."

The value of our intangible assets may become impaired.

Goodwill and other intangible assets represent a significant portion of our assets. Goodwill and other intangible assets were approximately $570.7 million as of December 31, 2014, representing approximately 11 percent of our total assets and 33 percent of our consolidated stockholders' equity at December 31, 2014.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to income may be necessary. This impairment testing requires us to make assumptions and judgments regarding estimated fair value including assumptions and estimates related to future earnings and membership levels based on current and future plans and initiatives, long-term strategies and our annual planning and forecasting processes, as well as the expected weighted average cost of capital used in the discount process. If estimated fair values are less than the carrying values of goodwill and other intangible assets, we may be required to record impairment losses against income. Any future evaluations resulting in an impairment of our goodwill and other intangible assets could materially impact our results of operations and stockholders' equity in the period in which the impairment occurs. A material decrease in stockholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

From time to time, we divest assets or businesses that we believe are less of a strategic fit for the company or do not produce an adequate return. Any such divestiture could result in significant asset impairment charges, including those related to goodwill and other intangible assets, which could have a material adverse effect on our financial condition and results of operations. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Critical Accounting Estimates—Goodwill and Other Intangible Assets" for further discussion of our procedures related to goodwill and other intangible assets.

The value of our investment portfolio and our goodwill could be adversely impacted by varying economic and market conditions which could, in turn, have a negative effect on our results of operations and stockholders' equity.

Our investment portfolio is comprised primarily of available-for-sale investment securities such as interest-yielding debt securities of varying maturities. As of December 31, 2014, our available-for-sale investment securities were approximately $1.8 billion. The value of fixed-income securities is highly sensitive to fluctuations in short- and long-term interest rates, with the value decreasing as such rates increase and increasing as such rates decrease. These securities may also be negatively impacted by illiquidity in the market. We closely monitor the fair values of our investment securities and regularly evaluate them for any other-than-temporary impairments. We have the intent and ability to hold our investments for a sufficient period of time to allow for recovery of the principal amount invested.

The current economic environment and the volatility of capital markets could negatively impact the liquidity of investments, such as the debt securities we hold, and a worsening in these markets could have negative effects on the liquidity and value of our investment assets. In addition, such uncertainty has increased the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets.

Over time, the economic and capital market environment may decline or provide additional insight regarding the fair value of certain securities, which could change our judgment regarding the impairment of certain investments. This could result in realized losses relating to other-than-temporary declines being charged against future income. There is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods, which could have an adverse effect on our results of operations, liquidity and financial condition. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources" for additional information regarding our investment portfolio.

In addition, our regulated subsidiaries are also subject to state laws and regulations that govern the types of investments that are allowable and admissible in those subsidiaries' portfolios. There can be no assurance that our investment assets will produce total positive returns or that we will not sell investments at prices that are less than the carrying value of these investments. Changes in the value of our investment assets, as a result of interest rate fluctuations, illiquidity or otherwise, could have a negative effect on our stockholders' equity. In addition, if it became necessary for us to liquidate our investment portfolio on an accelerated basis, it could have an adverse effect on our results of operations.

If our stock price experiences significant fluctuations or if our market capitalization materially declines, we could be required to take an impairment charge to reduce the carrying amount of our goodwill. If we were required to take such a charge, it would be non-cash and would not affect our liquidity or financial condition, but could have a significant adverse effect on our results of operations in the period in which the charge was taken.

The market price of our common stock is volatile.

The market price of our common stock is subject to volatility, and, although the price of our common stock rose significantly in 2014, it has shown significant volatility in years past. In 2012, the per share value of our common stock decreased by 20.1%. In 2013, the per share value of our common stock increased by 21.8%, and in 2014, the per share value of our common stock increased by 82.3%. There can be no assurance that the trading price of our common stock will vary in a manner consistent with the variation in the Standard & Poor's 400 Mid-Cap Index of which our common stock is a component. The market prices of our common stock and the securities of certain other publicly-traded companies in our industry have in the past or may in the future show significant volatility and sensitivity in response to many factors, including, without limitation, the ACA and health care reform generally, public communications regarding managed care, legislative or regulatory actions, political developments, developments in connection with our master services agreement with Cognizant, litigation or threatened litigation, health care cost trends, proposed premium increases, pricing trends, reductions in government reimbursement, competition, earnings, proposed changes in or the introduction of new government programs or initiatives, developments with respect to the CCI, receivable collections or membership reports of particular industry participants, and market speculation about or actual merger and acquisition activity. Additionally, adverse developments affecting any one of the companies in our sector could cause the price of our common stock to weaken, even if those adverse developments do not otherwise affect us. There can be no assurances regarding the level or stability of our share price at any time or the impact of these or any other factors on our stock price.

Securities class action lawsuits are often brought against companies after periods of volatility in the market price of their securities. If we were to become involved in securities litigation, it could subject us to substantial costs, divert resources and the attention of management from our business, and otherwise adversely affect our business.

Negative publicity regarding the managed health care industry and health care reform could adversely affect our ability to market and sell our products and services.

Managed health care companies have received and continue to receive negative publicity reflecting the public perception of the industry. For example, the Company and the managed health care industry have been subject to negative publicity surrounding premium rate increases and government investigations into the industry and our own business practices. Such risks may be exacerbated in the event we and other companies in our industry raise premium rates by more than has been done in recent years to price for the expanded benefits required by, and the fees, taxes and assessments imposed by, the ACA or to respond to any increase in medical cost trends. In addition, health care, health care reform and its implementation and related health care reform proposals have been and are expected to continue to be the subject of intense media attention and political debate. Such political discourse can often generate publicity that portrays managed care in a negative light. Our marketing efforts may be affected by, among other things, the amount of negative publicity to which the industry has been subject, as well as by speculation and uncertainty relating to merger and acquisition activity among companies in our industry. Speculation, uncertainty or negative publicity about us, our industry, our third party vendors or our lines of business could adversely affect our ability to market and sell our products or services, require changes to our products or services, or stimulate additional legislation, regulation, review of our practices or those of the industry or litigation that could adversely affect us.

Managing executive succession and retention is critical to our success. If we are unable to manage the succession of our key executives, it could adversely affect our business.

We are dependent on retaining existing key executives and attracting additional qualified executives to meet current and future needs. We face intense competition for qualified executives, and there can be no assurance that we will be able to attract and retain such executives. Although we have succession plans in place and have employment arrangements with our key executives, these do not guarantee that the services of these key executives will continue to be available to us or that we will be able to attract and retain suitable successors. We would be adversely affected if we fail to adequately plan for future turnover of our senior management team.

Acquisitions, divestitures and other significant transactions may adversely affect our business.

We continue to evaluate the profitability realized or that we expect to be realized by our existing businesses and operations. From time to time we review, from a strategic standpoint, potential acquisitions and divestitures in light of our core businesses and growth strategies. The success of any such acquisition or divestiture depends, in part, upon our ability to identify suitable buyers or sellers, negotiate favorable contractual terms and, in many cases, obtain governmental approval. For acquisitions, success is also dependent upon efficiently integrating the acquired business into our existing operations. For divestitures, success may also be dependent upon efficiently reducing general and administrative or other functions for our remaining operations. In the event the structure of the transaction results in continuing obligations by the buyer to us or our customers, a buyer's inability to fulfill these obligations could lead to future financial loss on our part. As a seller, we may have significant continuing indemnification, administrative services or other obligations to the buyer. Potential acquisitions or divestitures present financial, managerial and operational challenges, including diversion of management attention from existing businesses, difficulty with integrating or separating personnel and financial and other systems, significant post-closing obligations, increased expenses, assumption of unknown liabilities, indemnities and potential disputes with the buyers or sellers.

Our revolving credit facility contains restrictive covenants that could limit our ability to pursue our business strategies.

Our $600 million revolving credit facility due in October 2016 requires us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. Our revolving credit facility also requires us to comply with a maximum leverage ratio and a minimum fixed charge coverage ratio. See “Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations-Liquidity and Capital Resources-Capital Structure-Revolving Credit Facility” for further details regarding our revolving credit facility.

The restrictive covenants under our revolving credit facility could limit our ability to pursue our business strategies. In addition, any failure by us to comply with these restrictive covenants could result in an event of default under the revolving credit facility and, in some circumstances, under the indenture governing our Senior Notes, which, in any case, could have a material adverse effect on our financial condition.

We are dependent on our ability to recruit, manage, enable and retain a skilled and talented workforce.

Our products and services and our operations require a large number of employees. As of December 31, 2014, we employed 7,922 individuals on a full-time basis and 92 individuals on a part-time or temporary basis. It is critical that we recruit, manage, enable and retain talent to successfully execute our strategic objectives, which requires aligned policies, a positive work environment and a robust succession and talent development process. Further, particularly in light of the changing health care environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. Our business could be adversely affected if we are unable to recruit, manage, enable and retain talent and meet upcoming challenges and opportunities. In addition, the impact of the external or internal environment or other factors on employee morale, enablement and engagement could also significantly impact the success of the Company.

Our forecasts and other forward-looking statements are based on a variety of assumptions that are subject to significant uncertainties. Our performance may not be consistent with these forecasts and forward-looking statements.

From time to time in press releases and otherwise, we publish forecasts or other forward-looking statements regarding our future results, including estimated revenues, net earnings and other operating and financial metrics. Any forecast of our future performance reflects various assumptions. These assumptions are subject to significant uncertainties, and, as a matter of course, any number of them may prove to be incorrect.

The achievement of any forecast depends on numerous risks and other factors, including those described in this report, many of which are beyond our control. In addition, the uncertainties associated with federal and state health care reform, challenging economic conditions and our potential participation in new government programs or the provision of new services and/or benefits to new populations, among other things, may make it particularly difficult to forecast our future performance. As a result, we cannot assure that our performance will meet any management forecasts or that the variation from such forecasts will not be material and adverse. You are cautioned not to base your entire analysis of our business and prospects upon isolated predictions, but instead are encouraged to utilize the entire mix of publicly available historical and forward-looking information, as well as other available information affecting us, our services, and our industry when evaluating our forecasts and other forward-looking statements relating to our operations and financial performance.

It may be difficult for a third party to acquire us, which could decrease the value of your shares of our common stock.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, federal antitrust laws apply to us, and any change in control of our state health plans or health insurance companies also would require the approvals of the applicable regulatory agencies in each state in which we operate.

In addition to the Rights Agreement, our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of the Company that our stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay for shares of our common stock.

Large-scale public health epidemics and/or terrorist activity could cause us to incur unexpected health care and other costs and could materially and adversely affect our business, financial condition and results of operations.

An outbreak of a pandemic disease and/or future terrorist activities, including bio-terrorism, could materially and adversely affect the U.S. economy in general and the health care industry specifically. Depending on the government's actions and the responsiveness of public health agencies and insurance companies, a large-scale public health epidemic or future acts of bio-terrorism could lead to, among other things, increased utilization of health care services and the associated increased health care costs due to increased in-patient and out-patient hospital costs, disruption of information and payment systems and the cost of any anti-viral or other medication used to treat affected people.

Disasters, including earthquakes, fires and floods, could severely damage or interrupt our systems and operations and result in an adverse effect on our business, financial condition or results of operations.

Disasters such as fires, floods, earthquakes, tornados, power losses, virus outbreaks, telecommunications failures, break-ins or similar events could severely damage or interrupt our systems and operations, result in loss of data, and/or delay or impair our ability to service our members and providers. We have in place a disaster recovery plan that is intended to provide us with the ability to recover our critical information technology systems in the event of a natural disaster utilizing various alternate sites provided by a national disaster recovery vendor. We also have business continuity plans that provide for the processes and resources necessary to operate during and following a disaster. However, there can be no assurance that such adverse effects will not occur in the event of a disaster. Any such disaster or similar event could have a material adverse effect on our business, financial condition and results of operations.

Under the agreements that govern the Northeast Sale, we have retained responsibility for certain liabilities of the acquired business, which could have an adverse effect on our business, financial condition and results of operations.

Under the Stock Purchase Agreement for the Northeast Sale, we are required to indemnify the Buyer and its affiliates for all pre-closing liabilities of the acquired business and for a broad range of excluded liabilities, including liabilities arising out of the acquired business incurred through the winding-up and running-out period of the acquired business. The Stock Purchase Agreement does not limit the amount or duration of our obligations to the Buyer and its affiliates with respect to these indemnities. As a result, in the event that the amount of these liabilities was to exceed our expectations, we could be responsible to the Buyer and its affiliates for substantial indemnification obligations, which could have an adverse effect on our business, financial condition and results of operations.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- any requirement to restate financial results in the event of inappropriate application of accounting principles;
- a significant failure of our internal control over financial reporting;
- our inability to convert to international financial reporting standards, if required;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

We lease office space for our principal executive offices in Woodland Hills, California, which is used by each of our reportable segments. The operating lease for our executive offices expires on December 31, 2017 and relates to approximately 115,488 square feet. We also lease a separate 333,954 square foot facility in Woodland Hills primarily to house the operations for a significant portion of our Western Regions Operations reportable segment. The lease for this two-building facility expires December 31, 2021.

In Rancho Cordova and San Rafael, California, we lease an aggregate of approximately 592,650 square feet of office space that is used for operations in our Western Region Operations and Government Contracts reportable segments. The related leases expire at various dates ranging from February 2016 to June 2022.

In addition to the office space referenced above, we lease approximately 49 sites in 10 states, totaling approximately 628,794 square feet of space, which are used by our reportable segments for their respective operations. We also lease approximately 389,754 square feet of office space in Shelton, Connecticut under leases expiring at various dates ranging from 2016 to 2017. We no longer conduct operations in Shelton, and have subleased a portion of this space under subleases expiring at various dates ranging from 2016 to 2017.

We also own a facility in Rancho Cordova, California comprising approximately 82,000 square feet of space, which is used to support operations for all of our reportable segments.

We believe that our properties are adequate and suitable to meet our business needs.

Item 3. Legal Proceedings.

Overview

We record reserves and accrue costs for certain legal proceedings and regulatory matters to the extent that we determine an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect our best estimate of the probable loss for such matters, our recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to that they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings, each with a wide range of potential outcomes; or result in a change of business practices. Further, there may be various levels of judicial review available to the Company in connection with any such proceeding in the event damages are awarded or a fine or penalty is assessed. As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period our financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including those described below in this Item 3 under the heading “Military and Family Life Counseling Program Putative Class and Collective Actions,” depending, in part, upon our financial condition, results of operations, cash flow or liquidity in such period, and our reputation may be adversely affected. Except for the regulatory and legal proceedings discussed in this Item 3 under the heading “Military and Family Life Counseling Program Putative Class and Collective Actions,” management believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against us should not have a material adverse effect on our financial condition, results of operations, cash flow and liquidity.

Military and Family Life Counseling Program Putative Class and Collective Actions

We are a defendant in three related litigation matters pending in the United States District Court for the Northern District of California (the “Northern District of California”) relating to the independent contractor classification of counselors (“MFLCs”) who contracted with our subsidiary, MHN Government Services, Inc. (“MHNGS”), to provide short-term, non-medical counseling at U.S. military installations throughout the country under our Military and Family Life Counseling (formerly Military and Family Life Consultants) program.

On June 14, 2011, two former MFLCs filed a putative class action in the Superior Court of the State of Washington for Pierce County against Health Net, Inc., MHNGS, and MHN Services d/b/a MHN Services Corporation (also a subsidiary), on behalf of themselves and a proposed class of current and former MFLCs who have performed services as independent contractors in the state of Washington from June 14, 2008 to the present. Plaintiffs claim that MFLCs were misclassified as independent contractors under Washington law and are entitled to the wages and overtime pay that they would have received had they been classified as non-exempt employees. Plaintiffs seek unpaid wages, overtime pay, statutory penalties, attorneys’ fees and interest. We moved to compel the case to arbitration, and the court denied the motion on September 30, 2011. We appealed the decision. The Washington Supreme Court affirmed the trial court’s decision on August 15, 2013. On February 26, 2014, we removed this case to the United States District Court for the Western District of Washington, pursuant to the Class Action Fairness Act.

On May 15, 2012, the same two MFLCs who filed the Washington action, as well as 12 other named plaintiffs, filed a proposed collective action lawsuit against the same defendants in the United States District Court for the Western District of Washington on behalf of themselves and other current and former MFLCs who have performed services as independent contractors nationwide from May 15, 2009 to the present. They allege misclassification under the federal Fair Labor Standards Act (“FLSA”) and seek unpaid wages, unpaid benefits, overtime pay, statutory penalties, attorneys’ fees and interest. They also seek penalties under California Labor Code section 226.8. The court has since transferred the case to the Northern District of California to relate it to a virtually identical suit filed on October 2, 2012 against MHNGS and Managed Health Network, Inc. (“MHN”) (also a subsidiary).

The third October 2012 suit alleges misclassification under the FLSA on behalf of a nationwide class, as well under several state laws on behalf of MFLCs who worked in California, New Mexico, Hawaii, Kentucky, New York, Nevada, and North Carolina. On October 24, 2013, the parties agreed to toll the statutes of limitations for overtime violations in the following states: Alaska, Colorado, Illinois, Maine, Maryland, Massachusetts, Montana, New Jersey, North Dakota, Ohio, and Pennsylvania.

On November 1, 2012, we moved to compel arbitration in the Northern District of California, and the court denied the motion on April 3, 2013. We noticed our appeal of that decision to the United States Court of Appeals for the Ninth Circuit on April 8, 2013. On April 25, 2013, the district court granted Plaintiffs’ motion for conditional FLSA collective action certification to allow notice to be sent to the FLSA collective action members. The court stayed all other proceedings pending an outcome in the Ninth Circuit appeal. On December 17, 2014, a divided (2-1) Ninth Circuit panel affirmed the district court’s decision denying our motion to compel arbitration. On January 14, 2015, we petitioned for rehearing en banc, and the Ninth Circuit denied the petition on February 9, 2015. On February 13, 2015, the Ninth Circuit granted our motion to stay the proceedings, and the proceedings will remain stayed until the final disposition by the U.S. Supreme Court of our petition for a writ of certiorari.

On March 28, 2014, the original Washington case was transferred to the Northern District of California to relate it to the two FLSA suits pending there. On April 11, 2014, we moved to stay the suit pending the Ninth Circuit appeal. We also filed two alternative motions seeking an order to either compel the case to arbitration or dismiss Plaintiffs’ class claims and California Labor Code section 226.8 claims. On June 3, 2014, the court granted our motion to stay, and denied the later alternative motions without prejudice to renewal after the stay is lifted.

We intend to vigorously defend ourselves against these claims; however, these proceedings are subject to many uncertainties.

Miscellaneous Proceedings

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

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

We intend to vigorously defend ourselves against the miscellaneous legal and regulatory proceedings to which we are currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against us, substantial non-economic or punitive damages are being sought.

Potential Settlements

We regularly evaluate legal proceedings and regulatory matters pending against us, including those described above in this Item 3, to determine if settlement of such matters would be in the best interests of the Company and its stockholders. The costs associated with any settlement of the various legal proceedings and regulatory matters to which we are or may be subject from time to time, including those described above in this Item 3, could be substantial and, in certain cases, could result in a significant earnings charge or impact on our cash flow in any particular quarter in which we enter into a settlement agreement and could have a material adverse effect on our financial condition, results of operations, cash flow and/or liquidity and may affect our reputation.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

Item 5. Market For Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

The following table sets forth the high and low sales prices of the Company's common stock, par value $.001 per share, on The New York Stock Exchange ("NYSE") since January 2013.

	High	Low
Calendar Quarter—2013		
First Quarter	$29.57	$24.16
Second Quarter	$33.30	$26.69
Third Quarter	$33.90	$29.11
Fourth Quarter	$33.52	$25.40
Calendar Quarter—2014		
First Quarter	$35.10	$29.36
Second Quarter	$41.84	$31.36
Third Quarter	$47.53	$41.19
Fourth Quarter	$54.36	$43.61

On February 23, 2015, the last reported sales price per share of our common stock was $57.82 per share.

Securities Authorized for Issuance Under Equity Compensation Plans

Information regarding the Company's equity compensation plans is incorporated by reference in Part III of this Annual Report on Form 10-K under "Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters."

Holders of Common Stock

As of February 23, 2015, there were 1,517 registered holders of record of our common stock.

Dividends

We have not paid any dividends on our common stock during the preceding two fiscal years. We have no present intention of paying any dividends on our common stock, although the matter will be periodically reviewed by our Board of Directors.

We are a holding company and, therefore, our ability to pay dividends depends on distributions received from our subsidiaries, which are subject to regulatory net worth requirements and 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 our Board of Directors and depends upon our earnings, financial position (including cash position), capital requirements and such other factors as our Board of Directors deems relevant.

Under our revolving credit facility, we cannot declare or pay cash dividends to our stockholders or purchase, redeem or otherwise acquire shares of our capital stock or warrants, rights or options to acquire such shares for cash except to the extent permitted under the revolving credit facility, which is described in "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Capital Structure."

Stock Repurchase Program

On May 2, 2011, our Board of Directors authorized our stock repurchase program pursuant to which a total of $300 million of our outstanding common stock could be repurchased. On March 8, 2012, our Board of Directors approved a $323.7 million increase to our stock repurchase program, which, when taken together with the remaining authorization at that time, brought our total authorization up to $400.0 million.

On December 16, 2014, our Board of Directors approved another increase to our stock repurchase program in the amount of $257.8 million, which, when taken together with the remaining authorization at that time, brought our total authorization up to $400.0 million. The remaining authorization under our stock repurchase program as of December 31, 2014 was $400.0 million.

Subject to the approval of our Board of Directors, we may repurchase our common stock under our stock repurchase program from time to time in privately negotiated transactions, through accelerated stock repurchase programs or open market transactions, including pursuant to a trading plan in accordance with Rules 10b5-1 and 10b-18 of the Securities Exchange Act of 1934. The timing of any repurchases and the actual number of shares of stock repurchased will depend on a variety of factors, including the stock price, corporate and regulatory requirements, restrictions under the Company's debt obligations, and other market and economic conditions. Our stock repurchase program may be suspended or discontinued at any time.

During the year ended December 31, 2014, we repurchased 3.0 million shares of our common stock for aggregate consideration of $137.8 million under our stock repurchase program. For additional information on our stock repurchase program, see Note 9 to our consolidated financial statements.

Under our various stock option and long-term incentive plans, in certain circumstances, employees and non-employee directors may elect for the Company to withhold shares to satisfy minimum statutory federal, state and local tax withholding and/or exercise price obligations, as applicable, arising from the exercise of stock options. For certain other equity awards, we have the right to withhold shares to satisfy any tax obligations that may be required to be withheld or paid in connection with such equity award, including any tax obligation arising on the vesting date. These repurchases were not part of our stock repurchase program.

The following table presents monthly information related to repurchases of our common stock, including shares withheld by the Company to satisfy tax withholdings and exercise price obligations in 2014, as of December 31, 2014:

Period	Total Number of Shares Purchased (a)		Average Price Paid per Share	Total Price Paid	Total Number of Shares Purchased as Part of Publicly Announced Programs (b)	Maximum Dollar Value of Shares (or Units) that May Yet Be Purchased Under the Programs (b)
January 1—January 31	7,545	(c)	$ 33.25	$ 250,843	—	$ 280,000,018
February 1—February 28	268,851	(c)	32.05	8,617,165	—	$ 280,000,018
March 1—March 31	261,001	(c)	34.17	8,917,445	—	$ 280,000,018
April 1—April 30	2,645	(c)	33.49	88,589	—	$ 280,000,018
May 1—May 31	5,975	(c)	39.22	242,204	—	$ 280,000,018
June 1—June 30	748	(c)	39.82	29,785	—	$ 280,000,018
July 1—July 31	809	(c)	43.47	35,168	—	$ 280,000,018
August 1—August 31	3,807	(c)	43.10	164,085	—	$ 280,000,018
September 1—September 30	1,591,553	(c)	46.54	74,075,436	1,482,000	$ 211,030,239
October 1—October 31	1,521,589	(c)	45.32	68,958,807	1,518,000	$ 142,235,079
November 1—November 30	4,677	(c)	49.55	231,745	—	$ 142,235,079
December 1—December 31	4,947	(c)	53.81	266,199	—	$ 400,000,000
	3,674,147		$ 44.06	$ 161,877,471	3,000,000	

____

(a) During the year ended December 31, 2014, we did not repurchase any shares of our common stock outside our publicly announced stock repurchase programs, except shares withheld in connection with our various stock option and long-term incentive plans.

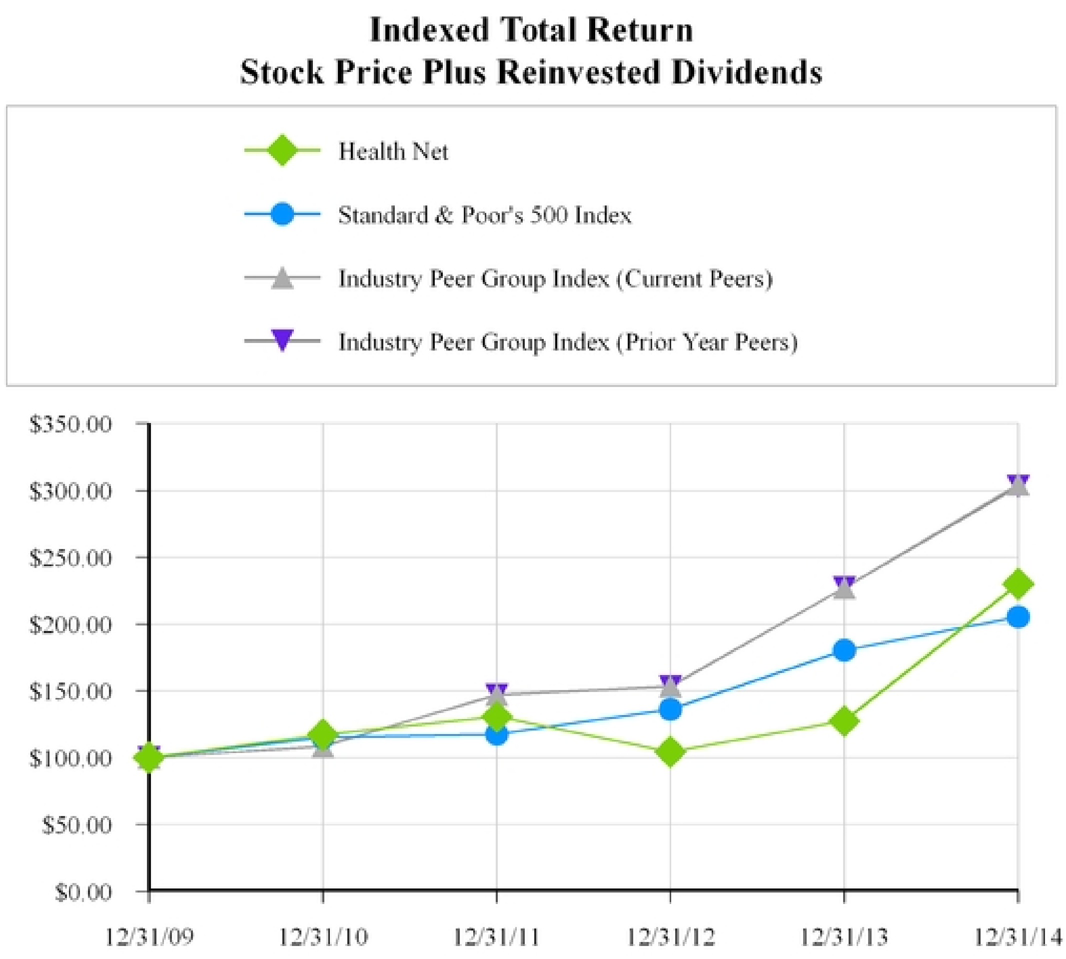
(b) On May 2, 2011, our Board of Directors authorized our stock repurchase program, pursuant to which a total of $300 million of our common stock could be repurchased. On March 8, 2012, our Board of Directors approved a $323.7 million increase to our stock repurchase program. On December 16, 2014, our Board of Directors approved another $257.8 million increase to our stock repurchase program, which, when taken together with the remaining authorization at that time, brought our total authorization up to $400 million. Our stock repurchase program does not have an expiration date. During the year ended December 31, 2014, we did not have any repurchase program expire, and we did not terminate any repurchase program prior to its expiration date.

(c) Includes shares withheld by the Company to satisfy tax withholding and/or exercise price obligations arising from the vesting and/or exercise of restricted stock units, stock options and other equity awards.

Performance Graph

The following graph compares the performance of the Company's Common Stock with the performance of the Standard & Poor's 500 Composite Stock Price Index (the "S&P 500 Index") and both the current and prior year Industry Peer Group Index. We calculate year-end values based on the closing prices from the final trading days in December 2009, 2010, 2011, 2012, 2013, and 2014. The graph assumes that $100 was invested on December 31, 2009 in each of the Common Stock, the S&P 500 Index, and the current year Industry Peer Group Index and the prior year Industry Peer Group Index, and that all dividends were reinvested for both the current and prior year. The Industry Peer Group Index weights the constituent companies' stock performance on the basis of market capitalization at the beginning of each annual period.

The Company's current Industry Peer Group Index includes the following companies: Aetna, Inc., Cigna Corporation, Humana, Inc., UnitedHealth Group, Inc., Anthem, Inc. (formerly WellPoint, Inc.), Molina Healthcare, Inc., Centene Corporation, and WellCare Health Plans, Inc.. In our previous annual report on Form 10-K for the year ended December 31, 2013, the Company used an Industry Peer Group Index comprised of Aetna, Inc., Cigna Corporation, Humana, Inc., UnitedHealth Group, Inc., and WellPoint, Inc. This year, the Company elected to add the following three new companies to the peer group based on their strong presence in the Medicaid market: Molina Healthcare, Inc., Centene Corporation and WellCare Health Plans, Inc. The Company believes those additions will help the peer group more appropriately reflect the Company's current mix of business, which has experienced rapid growth in its Medicaid segment.



Indexed Total Return (Stock Price Plus Reinvested Dividends)

Name	12/31/2009	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014
Health Net	$ 100.00	$ 117.17	$ 130.61	$ 104.34	$ 127.39	$ 229.84
Standard & Poor's 500 Index	$ 100.00	$ 115.06	$ 117.49	$ 136.30	$ 180.44	$ 205.14
Industry Peer Group Index (Current Peers)	$ 100.00	$ 108.46	$ 147.17	$ 153.59	$ 227.10	$ 304.41
Industry Peer Group Index (Prior Year Peers)	$ 100.00	$ 108.70	$ 146.76	$ 153.30	$ 227.20	$ 303.00

All historical performance data reflects the performance of each company’s own stocks only and does not include the historical performance data of acquired companies.

The preceding graph and related information are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed “soliciting materials” or to be “filed” with the Securities and Exchange Commission (other than as provided in Item 201). Such information shall not be incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that we specifically incorporate it by reference into such filing.

Item 6. Selected Financial Data.

The following selected financial and operating data as of and for the years ended December 31, 2014, 2013, and 2012 are derived from our audited consolidated financial statements and notes thereto contained in this Annual Report on Form 10-K. The selected financial and operating data as of and for the years ended December 31, 2011 and 2010 are derived from our audited consolidated financial statements which are not included herein. The selected financial and operating data should be read in conjunction with "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" and the consolidated financial statements and notes thereto contained elsewhere in this Annual Report on Form 10-K.

	Year Ended December 31,				
	2014	2013	2012	2011	2010
	(Dollars in thousands, except per share and PMPM data)				
REVENUES:					
Health plan services premiums	$ 13,361,170	$ 10,377,073	$ 10,459,098	$ 9,878,687	$ 9,492,460
Government contracts	603,975	572,266	689,121	1,416,619	3,344,483
Net investment income	45,166	69,613	82,434	74,161	71,181
Administrative services fees and other income	(1,725)	34,791	17,968	11,523	21,126
Divested operations and services revenue	—	—	40,471	34,446	186,167
Total revenues	$ 14,008,586	$ 11,053,743	$ 11,289,092	$ 11,415,436	$ 13,115,417
INCOME SUMMARY (1):					
Income from continuing operations	$ 145,629	$ 170,126	$ 25,681	$ 61,056	$ 171,885
Income on discontinued operation, net of tax	—	—	96.382	11,064	32,358
Net income	$ 145,629	$ 170,126	$ 122,063	$ 72,120	$ 204,243
NET INCOME PER SHARE—DILUTED (1):					
Income from continuing operations	$ 1.80	$ 2.12	$ 0.31	$ 0.68	$ 1.73
Income of discontinued operation, net of tax	$ —	$ —	$ 1.16	$ 0.12	$ 0.33
Net income	$ 1.80	$ 2.12	$ 1.47	$ 0.80	$ 2.06
Weighted average shares outstanding:					
Diluted	80,777	80,404	83,112	89,970	99,232
BALANCE SHEET DATA:					
Cash and cash equivalents and investments available for sale	$ 2,664,763	$ 2,059,943	$ 2,152,622	$ 1,790,397	$ 2,022,112
Total assets	5,395,934	3,929,125	3,934,390	3,607,669	4,131,693
Loans payable—Long term	100,000	100,000	100,000	112,500	—
Senior notes payable	399,504	399,300	399,095	398,890	398,685
Total stockholders' equity (2)	1,709,222	1,628,811	1,557,030	1,443,146	1,694,416
OPERATING DATA:					
Pretax margin from continuing operations	1.4 %	2.4 %	0.3 %	1.4 %	2.1 %
Western Region Operations health plans services medical care ratio (MCR)	84.6%	85.6%	89.1 %	86.5 %	87.1 %
Western Region Operations total G&A expense ratio	10.9 %	10.3 %	8.6 %	8.6 %	8.5 %
Western Region Operations selling costs ratio	2.0 %	2.3 %	2.4 %	2.4 %	2.5 %
Western Region Operations health plan services premiums per member per month (PMPM)	$385.42	$349.92	$341.28	$322.28	$315.55
Western Region Operations health plan services costs PMPM	$319.82	$299.66	$304.01	$278.85	$274.70
Net cash provided by operating activities	$ 776,001	$ 95,389	$ 32,540	$ 103,380	$ 308,038
Net cash (used in) provided by investing activities	$ (184,852)	$ 579	$ (12,558)	$ 222.227	$ (200,593)
Net cash (used in) provided by financing activities	$ (155,171)	$ (3,373)	$ 89,875	$ (445,492)	$ (440,110)

CDIx435

(1) For 2014, includes an $88.5 million pretax asset impairment primarily related to our assets held for sale in connection with the Cognizant Transaction and $96.8 million of pretax expenses primarily related to the Cognizant Transaction. Our operating results for the year ended December 31, 2014 were also impacted by fees imposed under the ACA, including $141.4 million in amortization of deferred costs of health insurer fee and $97.6 million in other ACA fees. For 2013, we had approximately $56 million in favorable reserve

developments related to prior years. These reserve developments related to prior years when considered together with the provision for adverse deviation recorded as of December 31, 2013, did not have a material impact on our operating results or financial condition. In addition, our operating results for the year ended December 31, 2013 were impacted by $12.0 million in pretax costs primarily related to our continuing efforts to address scale issues. For 2012, includes a gain on sale of discontinued operation in the amount of $114.8 million after-tax. Our operating results for the year ended December 31, 2012 were impacted by approximately $35 million of adverse development related to prior years recorded as part of our health care cost. In addition, our operating results for the year ended December 31, 2012 were impacted by pretax costs of $35.6 million related to our G&A cost reduction efforts, a $5.0 million expense related to the early termination of a medical management contract and $1.3 million in litigation-related expenses net of an insurance reimbursement. For 2011, includes a $181 million pretax expense related to a litigation judgment in the first quarter. In addition, our operating results for the year ended December 31, 2011 were impacted by a $40.8 million favorable adjustment to loss on sale of Northeast health plan subsidiaries and a $6.8 million benefit from litigation reserve adjustments, partially offset by pretax costs of $25.2 million related to our G&A cost reduction efforts. For 2010, includes pretax charges of $61.2 million related to our operations strategy and other cost management initiatives, and $9.0 million in early debt extinguishment and related interest rate swap termination costs, partially reduced by a $46.5 million benefit from litigation reserve adjustments and a $42.0 million adjustment to loss on sale of Northeast health plan subsidiaries.

(2) No cash dividends were declared in any of the years presented.

Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations.

OVERVIEW

General

We are a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. Our mission is to help people be healthy, secure and comfortable. We provide and administer health benefits to approximately 6.0 million individuals across the country through group, individual, Medicare (including the Medicare prescription drug benefit commonly referred to as "Part D"), Medicaid, dual eligible, U.S. Department of Defense (“Department of Defense” or “DoD”), including TRICARE, and U.S. Department of Veterans Affairs ("VA") programs. We also offer behavioral health, substance abuse and employee assistance programs, managed health care products related to prescription drugs, managed health care product coordination for multi-region employers, and administrative services for medical groups and self-funded benefits programs.

How We Report Our Results

Our reportable segments are comprised of Western Region Operations and Government Contracts. Effective January 1, 2013, our Divested Operations and Services segment was closed out after we substantially completed the transition and run-out of our divested businesses, as further discussed below.

Our health plan services are provided under our Western Region Operations reportable segment, which includes the operations primarily conducted in California, Arizona, Oregon and Washington for our commercial, Medicare, Medicaid and dual eligibles health plans, our health and life insurance companies, our pharmaceutical services subsidiary and certain operations of our behavioral health subsidiaries. As of December 31, 2014, we had approximately 3.2 million medical members in our Western Region Operations reportable segment. On April 1, 2012, we completed the sale of our Medicare stand-alone prescription drug plan business ("Medicare PDP business") to Pennsylvania Life Insurance Company, a subsidiary of CVS Caremark Corporation ("CVS Caremark"). As a result, the operating results related to our Medicare PDP business have been excluded from continuing operations results and are classified in this Annual Report on Form 10-K as discontinued operations for the year ended December 31, 2012. Accordingly, the information included in this Annual Report on Form 10-K regarding our Western Region Operations reportable segment excludes the operating results of our Medicare PDP business for the year ended December 31, 2012. For additional information regarding the sale of our Medicare PDP business, see Note 3 to our consolidated financial statements.

Our Government Contracts segment includes our government-sponsored managed care contract with the DoD under the TRICARE program in the North Region and other health care related government contracts, including the Patient Centered Community Care program (“PC3 Program”) contract we have with VA. On April 1, 2011, we began delivery of administrative services under a new Managed Care Support Contract (“T-3 contract”) for the TRICARE North Region. Under the T-3 contract for the TRICARE North Region, we provide administrative services to approximately 2.8 million Military Health System (“MHS”) eligible beneficiaries. In addition, we also provide behavioral health services to military families under the Department of Defense Military and Family Life Counseling, formerly Military and Family Life Consultant (“MFLC”) contract, which is also included in our Government Contracts segment. See Note 2 to our consolidated financial statements under the heading “Government Contracts” for additional information on the T-3, MFLC and PC3 Program contracts.

On November 2, 2014, we signed a definitive master services agreement with Cognizant Healthcare Services, LLC, a wholly owned subsidiary of Cognizant Technology Solutions Corporation ("Cognizant") to provide certain services to us. In connection with this agreement, we have also entered into an asset purchase agreement pursuant to which we have agreed to sell certain software assets and related intellectual property we own to Cognizant. The transaction, including the related asset sale (the "Cognizant Transaction"), is subject to receipt of required regulatory approvals. In connection with the Cognizant Transaction, we reviewed our reportable segments and determined that there were no changes to our reportable segments. See Note 3 to our consolidated financial statements under the heading “Assets Held for Sale” for additional information on the Cognizant Transaction.

Prior to January 1, 2013, our Divested Operations and Services reportable segment included the operations of our businesses that provided administrative and run-out support services to an affiliate of UnitedHealth Group Incorporated ("United") and its affiliates under administrative services and claims servicing agreements in connection with the Northeast Sale (as defined below), as well as the transition-related revenues and expenses of our divested Medicare PDP business. The "Northeast Sale" referred to the sale of all of the outstanding shares of capital stock of our health plan subsidiaries that were domiciled and/or had conducted businesses in Connecticut, New Jersey, New York and

Bermuda to United, and includes the acquisition by United of membership renewal rights for certain health care business conducted by our subsidiary, Health Net Life Insurance Company, in the states of Connecticut and New Jersey. As of December 31, 2012, we had substantially completed the transition and run-out of our divested businesses. See Note 2 to our consolidated financial statements under the heading “Divested Operations and Services” and Notes 3 and 14 to our consolidated financial statements for additional information regarding the Northeast Sale, the sale of our Medicare PDP business, and our reportable segments.

How We Measure Our Profitability

Our profitability depends in large part on our ability to, among other things, effectively price our health care products; accurately predict and effectively manage health care and pharmacy costs; effectively contract with health care providers; attract and retain members; and manage our general and administrative (“G&A”) and selling expenses. In addition, factors such as state and federal health care reform legislation and regulation, competition and general economic conditions affect our operations and profitability. The effect of escalating health care costs, as well as any changes in our ability to negotiate competitive rates with our providers, may impose further risks to our ability to profitably underwrite our business. Each of these factors may have a material impact on our business, financial condition or results of operations.

We measure our Western Region Operations reportable segment profitability based on pretax income, which is calculated as health plan services premiums and administrative services fees and other income less health plan services expense and G&A and other net expenses, including selling expenses. See “—Results of Operations—Western Region Operations Reportable Segment—Western Region Operations Segment Results” for a calculation of pretax income.

Health plan services premiums generally include health maintenance organization (“HMO”), point of service (“POS”) and preferred provider organization (“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 (which includes retroactive and retrospective premium adjustments), and revenue under Medicare risk contracts to provide care to enrolled Medicare recipients. Medicare revenues also can include amounts for risk factor adjustments and additional premiums that we charge in some places to members who purchase our Medicare risk plans. Health plan services premiums also includes our revenues from the California Coordinated Care Initiative (the "CCI") program. For additional information on the CCI, see "—Results of Operations—Western Region Operations Reportable Segment—California Coordinated Care Initiative."

The amount of premiums we earn in a given period is driven by the rates we charge and enrollment levels. Administrative services fees and other income primarily includes revenue for administrative services such as claims processing, customer service, medical management, provider network access and other administrative services.

Health plan services expense generally includes medical and related costs for health services provided to our members, including physician services, hospital and related professional services, outpatient care, and pharmacy benefit costs. These expenses are impacted by unit costs and utilization rates. Unit costs represent the health care cost per visit, and the utilization rates represent the volume of health care consumption by our members.

G&A expenses include, among other things, those costs related to employees and benefits, consulting and professional fees, marketing, business expansion and cost reduction initiatives, premium taxes and assessments, Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively, the "ACA") related fees, occupancy costs and litigation and regulatory-related costs. Such costs are driven by membership levels, introduction of new products or provision of new services, system consolidations, outsourcing activities and compliance requirements for changing regulations, among other things. These expenses also include expenses associated with corporate shared services and other costs to reflect the fact that such expenses are incurred primarily to support health plan services. Selling expenses consist of external broker commission expenses and generally vary with premium volume.

We measure our Government Contracts segment profitability based on pretax income, which is calculated as Government Contracts revenue less Government Contracts cost. See “—Results of Operations—Government Contracts Reportable Segment—Government Contracts Segment Results” for a calculation of the government contracts pretax income.

Under the T-3 contract for the TRICARE North Region, we provide various types of administrative services including provider network management, referral management, medical management, disease management, enrollment, customer service, clinical support service, and claims processing. These services are structured as cost reimbursement arrangements for health care costs plus administrative fees earned in the form of fixed prices, fixed unit prices, and contingent fees and payments based on various incentives and penalties. We recognize revenue related to administrative services on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE North Region members are served by our network and out-of-network providers in accordance with the T-3 contract. We pay health care costs related to these services to the providers and are later reimbursed by the DoD for such payments. Under the terms of the T-3 contract, we are not the primary obligor for health care services and accordingly, we do not include health care costs and related reimbursements in our consolidated statements of operations. The T-3 contract also includes various performance-based incentives and penalties. For each of the incentives or penalties, we adjust revenue accordingly based on the amount that we have earned or incurred at each interim date and are legally entitled to in the event of a contract termination. See Note 2 to our consolidated financial statements under the heading "Government Contracts" for additional information on our T-3 contract.

Other government contracts revenues are recognized in the month in which the eligible beneficiaries are entitled to health care services or in the month in which the administrative services are performed or the period that coverage for services is provided. See Note 2 to our consolidated financial statements under the heading "Government Contracts" for additional information on our other government contracts such as the MFLC contract and that PC3 Program.

Health Care Reform Legislation and Implementation

The ACA transformed the U.S. health care system through a series of complex initiatives. Due in part to the magnitude, scope and complexity of these initiatives, as well as their ongoing implementation, the ultimate impact of the ACA on us remains difficult to predict. The ACA has provided growth opportunities for health insurers, including us, but also introduces new risks and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. While we have experienced significant growth in our revenues and membership in certain products as a result of the ACA, the measures initiated by the ACA and the associated preparation for and implementation of these measures have had, and will continue to have, an adverse impact on, among other things, the costs of operating our business, and could materially adversely affect our business, cash flows, financial condition and results of operations.

For a detailed description of the ACA’s provisions and related health care reform programs, initiatives, rules and regulations, see "Item 1. Business-Government Regulation—Health Care Reform Legislation and Implementation." For additional discussion of some of our risks and uncertainties related to the ACA, including certain legal, legislative and regulatory developments, see "Item 1A. Risk Factors."

Medicaid Expansion

In connection with the ACA, the federal government extended funds to those states that opted to expand Medicaid eligibility from a pool that included residents with incomes up to 100% of the federal poverty level ("FPL") to an expanded pool of residents with incomes up to 133% of the FPL. Both Arizona and California are amongst the states that have opted into this "Medicaid expansion." In 2014, our total Medicaid membership increased by 50% as a result of Medicaid expansion. We anticipate continued Medicaid membership growth from the expansion, due in part to the backlog of Medi-Cal applications in process at the county level at the end of 2014, as well as the expected movement of some individuals from the exchanges population to Medicaid. For additional information on our Medicaid program, see "Item 1. Business-Segment Information—Western Region Operations Segment—Medicaid and Related Products."

Public Health Insurance Exchanges

The ACA also required the establishment of state-run or federally facilitated "exchanges" where individuals and small groups may purchase health coverage. We currently participate as Qualified Health Plans ("QHPs") in the exchanges in California and Arizona. In California, we currently operate in 13 of 19 exchange rating regions in California in the individual market and in all 19 exchange rating regions in the small business health options program ("SHOP").

We believe the exchanges represent a significant commercial business opportunity for us as our individual commercial enrollment increased nearly 190 percent during 2014, driven in large part by enrollment in the exchanges through the first open enrollment period. However, as we complete our second enrollment period, changing economic conditions, the dynamic competitive environment on the exchanges, various legislative and legal developments and the ongoing evolution of the regulatory framework for the exchanges, among other things, may alter the economics and structure of our participation in the exchanges, which remain a new marketplace with which we have limited experience. If we are not able to successfully adapt to any such changes in our markets, our financial condition, cash flows and results of operations may be adversely affected. For more information on the exchanges, including the attendant risks and enrollment information, see Note 2 to our consolidated financial statements, "—Western Region Operations Reportable Segment—Western Region Operations Segment Membership" and "Item 1A. Risk Factors."

Health Insurer Fee

Our operating results for the year ended December 31, 2014 were impacted by fees imposed under the ACA, including $141.4 of amortization of the deferred cost of the annual non-deductible health insurer fee calculated on 2013 net premiums written (the "health insurer fee"). In September 2014, we paid the federal government a lump sum of $141.4 million for our portion of the health insurer fee calculated based on 2013 premiums. In 2014, due to the non-deductibility of the health insurer fee for federal income tax purposes, our full-year effective income tax rate was adversely affected by 24.8 percentage points. While we are required to accrue for the health insurer fee on a pro rata basis throughout the year, in future years we could experience significant volatility in our cash flow from operations relative to our results of operations in a given period because the health insurer fee is payable in a single lump sum.

While certain types of entities and benefits are fully or partially exempt from the health insurer fee, including, among others, government entities, certain non-profit insurers and self-funded plans, we are unable to take advantage of any significant exemptions due to our current mix of plans and product offerings. Consequently, the health insurer fee represents a higher percentage of our premium revenues than those of our competitors who have business lines that are exempt from the health insurer fee or whose non-profit status results in a reduced health insurer fee. We generally are also unable to match those competitors' ability to support reduced premiums by virtue of making changes to distribution arrangements, decreasing spending on non-medical product features and services, or otherwise adjusting operating costs and reducing general and administrative expenses, which may have an adverse effect on our profitability and our ability to compete effectively with these competitors. For more information on this and other ACA related fees, including the associated risks, see Note 2 to our consolidated financial statements, "—Results of Operations—Consolidated Results" and "Item 1A. Risk Factors."

Premium Stabilization Programs

The ACA also includes premium stabilization provisions designed to apportion risk amongst insurers, including the reinsurance, risk adjustment, and risk corridors programs.

The permanent risk adjustment program is applicable to plans in the individual and small group markets that are subject to the ACA's market reforms. This risk adjustment program became effective at the beginning of 2014 and has and will continue to shape the economics of health care coverage both within and outside the exchanges. These risk adjustment provisions will effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against the consequences of adverse selection. In addition to these permanent risk adjustment provisions, the ACA implements temporary reinsurance and risk corridors programs, which seek to ease the transition into the post-ACA market by helping to stabilize rates and protect against rate uncertainty in the initial years of the ACA.

The individual and small group market represent a significant portion of our commercial business and the relevant amounts transferred under applicable premium stabilization provisions may be substantial. Calculating these premium stabilization provisions requires us to estimate receivables and payables. Until the final calculations are performed that determine the amounts collectible and payable, the estimates can vary and the final amounts may materially differ from those estimates. The final determination and settlement of amounts due or payable from these premium stabilization provisions for 2014 will not occur until at least June 2015. If we are required to make material adjustments from our prior estimates, our financial condition, cash flows and results of operations could be materially adversely affected.

We have made and are continuing to make significant efforts to design and implement a cohesive strategy with respect to the exchanges and these premium stabilization programs, but these programs are subject to risks inherent in untested initiatives, and the relevant regulatory framework for the exchanges remains subject to change and interpretation over time. Whether due to regulatory uncertainty or otherwise, if these premium stabilization programs prove ineffective in mitigating our financial risks, including adverse selection risk, or we are unable to successfully adapt our strategy to any future changes in our markets, our financial condition, cash flows and results of operations may be materially adversely affected. See Note 2 to our consolidated financial statements, "—Critical Accounting Estimates-Accounting for Certain Provisions of the ACA" and "Item 1A. Risk Factors" for additional information on these premium stabilization programs or "3Rs".

MLRs

Under the ACA, commercial health plans with medical loss ratios ("MLR") on fully insured products, as calculated as set forth in the ACA, that fall below certain targets are required to rebate ratable portions of their premiums annually. Certain of the states in which we operate include similar rebate provisions. For example, a medical loss ratio corridor for the California Department of Health Care Services ("DHCS") adult Medicaid expansion members under the Medicaid program in California ("Medi-Cal") requires rebate payments to or from DHCS depending on MLRs for this population. In addition, our Medicaid contract with the state of Arizona contains profit sharing or profit ceiling provisions under which we refund amounts to Arizona if our health plan generates profit above a certain specified percentage. During the year ended December 31, 2014, we accrued $200.6 million for a MLR rebate with respect to our adult Medicaid expansion population payable to DHCS and accrued $24.7 million, net of a $2.3 million receivable, for excess profit sharing payable to the state of Arizona under our Medicaid contract. Accordingly, for the year ended December 31, 2014, we reduced Medicaid premium revenue by $225.3 million. See Note 2 "Health Plan Services Revenue Recognition" section for further discussion on these MLR provisions.

We and other health insurance companies continue to face uncertainty and execution risk due to the multiple, complex ACA implementations that were and are required in abbreviated time frames in new markets. Additionally, in many cases, our operational and strategic initiatives must be implemented in evolving regulatory environments and without the benefit of established market data. In addition, the relative lack of operating experience in these new marketplaces for insurers and, in certain cases, providers and consumers, has fostered a dynamic marketplace that may require us to adjust our operating and strategic initiatives over time, and there is no assurance that insurers, including us, will be able to do so successfully. Our execution risk encapsulates, among other things, our simultaneous participation in the exchanges, Medicaid expansion and the CCI. These initiatives involved the incorporation of new and expanded populations and, among other things, have required that we restructure our provider network in response, and will require us to remain diligent in monitoring the market to, among other things, effectively and efficiently adapt to our dynamic environment. Any delay or failure by us to successfully execute our operational and strategic initiatives with respect to health care reform or otherwise appropriately react to the legislation, implementing regulations, actions of our competitors and the changing marketplace could result in operational disruptions, disputes with our providers or members, increased exposure to litigation, regulatory issues, damage to our existing or potential member relationships or other adverse consequences that could have an adverse impact on our business, financial condition, cash flows and results of operations.

Cognizant Transaction

On November 2, 2014, we entered into a Master Services Agreement (as subsequently amended and restated, the "Master Services Agreement") with Cognizant. Under the terms of the Master Services Agreement, Cognizant will, among other things, provide us with certain consulting, technology and administrative services in the following areas: claims management, membership and benefits configuration, customer contact center services, information technology, quality assurance, appeals and grievance services, and non-clinical medical management support (collectively, the "BP and IT Services").

Concurrent with executing the Master Services Agreement, we entered into an asset purchase agreement with Cognizant (the "Asset Purchase Agreement"), through which Cognizant will purchase certain software assets and related intellectual property from us for $50 million. See Note 3 to our consolidated financial statements under the heading “Assets Held for Sale” for additional information on the assets sold in this transaction.

The Cognizant Transaction is expected to close in the first half of 2015, subject to the receipt of required regulatory approvals. We expect that certain of our employees will become employees of Cognizant or its subcontractors, and that certain positions will be eliminated as part of the transaction.

The initial term of the Master Services Agreement is seven years, commencing on the later of (i) ten business days following final regulatory approval of the transaction, and (ii) March 1, 2015 (the "Commencement Date"). We have two options to extend the Master Services Agreement for one year each by giving notice to Cognizant no less than three months prior to the end of the then existing term.

We will pay Cognizant for the BP and IT Services through a combination of fixed and variable fees, with the variable fees fluctuating based on our actual need for such services. Based on the currently projected usage of BP and IT Services over the initial term of the Master Services Agreement, we expect to pay Cognizant approximately $2.8 billion, subject to price adjustments described in the Master Services Agreement. The Master Services Agreement is currently expected to generate approximately $150 million to $200 million in annual general and administrative and depreciation expense savings for us by 2017.Our operating results in our Corporate/Other segment for the year ended December 31, 2014 were impacted by an $88.5 million pretax asset impairment primarily related to our assets held for sale in connection with the Cognizant Transaction. See Note 3 to our consolidated financial statements and "Item 1. Business—Additional Information Concerning Our Business—Cognizant Transaction" for additional information regarding assets held for sale and the Cognizant Transaction. In addition, our operating results in our Corporate/Other segment for the year ended December 31, 2014 were impacted by $74.8 million in pretax expenses related to the Cognizant Transaction. The Cognizant Transaction is subject to certain risks and uncertainties, including with respect to the receipt of required regulatory approvals, which are discussed in further detail in "Item 1A. Risk Factors."

2014 Financial Performance Summary

Health Net’s financial performance in 2014 is summarized as follows:

- In the year ended December 31, 2014, we reported net income of $145.6 million or $1.80 per diluted share as compared to net income of $170.1 million or $2.12 per share, for the same period in 2013.
- Western Region Operations enrollment was approximately 3.2 million as of December 31, 2014, an increase of 29.1 percent compared with enrollment at December 31, 2013.
- Total revenues for the year ended December 31, 2014 increased by approximately 26.7 percent to $14.0 billion from the same period in 2013.
- Western Region Operations segment pretax income increased to $315.6 million in 2014 compared to $207.5 million in 2013.
- Government Contracts segment pretax income decreased to $69.5 million in 2014 compared to $74.5 million in 2013.
- Net cash provided by operating activities totaled $776.0 million for the year ended December 31, 2014 compared to $95.8 million for the same period in 2013.
- Our operating results for the year ended December 31, 2014 were impacted by:
    - Fees imposed under the ACA, including $141.4 million for the health insurer fee and $97.6 million in other ACA fees. See Note 2 to our consolidated financial statements under the heading "Accounting for Certain Provisions of the ACA" for additional information.
    - An $88.5 million pretax asset impairment primarily related to our assets held for sale in connection with the Cognizant Transaction and $96.8 million of pretax expenses primarily related to the Cognizant Transaction. See Note 3 to our consolidated financial statements under the heading “Assets Held for Sale” for additional information regarding the Cognizant Transaction.
    - A loss on the stock of one of our subsidiaries that created a tax benefit of $73.7 million, net of adjustments to our reserve for uncertain tax benefits. See Note 11 to our consolidated financial statements for additional information.

RESULTS OF OPERATIONS

Consolidated Results

The table below and the discussion that follows summarize our results of operations for the years ended December 31, 2014, 2013 and 2012.

	Year Ended December 31,		
	2014	2013	2012
	(Dollars in thousands, except per share data)		
Revenues			
Health plan services premiums	$ 13,361,170	$ 10,377,073	$ 10,459,098
Government contracts	603,975	572,266	689,121
Net investment income	45,166	69,613	82,434
Administrative services fees and other income	(1,725)	34,791	17,968
Divested operations and services revenue	—	—	40,471
Total revenues	14,008,586	11,053,743	11,289,092
Expenses			
Health plan services (excluding depreciation and amortization)	11,307,751	8,886,547	9,316,313
Government contracts	536,643	502,918	605,074
General and administrative	1,552,364	1,083,694	939,940
Selling	262,338	239,428	245,925
Depreciation and amortization	29,786	38,589	31,146
Interest	31,376	32,614	33,220
Divested operations and services expenses	—	—	85,824
Asset impairment	88,536	—	—
Total expenses	13,808,794	10,783,790	11,257,442
Income from continuing operations before income taxes	199,792	269,953	31,650
Income tax provision	54,163	99,827	5,969
Income from continuing operations	145,629	170,126	25,681
Discontinued operations:			
(Loss) income from discontinued operation, net of tax	—	—	(18,452)
Gain on sale of discontinued operation, net of tax	—	—	114,834
Income on discontinued operation, net of tax	—	—	96,382
Net income	$ 145,629	$ 170,126	$ 122,063
Net income per share—basic:			
Income from continuing operations	$ 1.83	$ 2.14	$ 0.31
Income on discontinued operation, net of tax	$ —	$ —	$ 1.18
Net income per share—basic	$ 1.83	$ 2.14	$ 1.49
Net income per share—diluted:			
Income from continuing operations	$ 1.80	$ 2.12	$ 0.31
Income on discontinued operation, net of tax	$ —	$ —	$ 1.16
Net income per share—diluted	$ 1.80	$ 2.12	$ 1.47

Summary of Operating Results

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

In the year ended December 31, 2014, we reported net income of $145.6 million or $1.80 per diluted share as compared to net income of $170.1 million or $2.12 per diluted share for the same period in 2013. Pretax margin was 1.4 percent for 2014 compared to 2.4 percent for 2013.

Our total revenues increased 26.7 percent in the year ended December 31, 2014 to $14.0 billion from $11.1 billion in the same period in 2013.

Health plan services premiums revenues increased to $13.4 billion in the year ended December 31, 2014, compared with $10.4 billion in the year ended December 31, 2013. Health plan services expenses increased by 27.2 percent from $8.9 billion in the year ended December 31, 2013 to $11.3 billion in the year ended December 31, 2014. Net investment income decreased to $45.2 million in the year ended December 31, 2014 compared with $69.6 million in the year ended December 31, 2013.

Our government contracts revenues increased by 5.5 percent in 2014 to $604.0 million from $572.3 million in 2013. Our government contracts costs increased by 6.7 percent in 2014 to $536.6 million from $502.9 million in 2013. The increases in our government contracts revenues and costs were primarily due to services provided for the PC3 Program. For additional information see “—Government Contracts Reportable Segment".

Our general and administrative (G&A) expenses increased by $468.7 million, or 43 percent, in the year ended December 31, 2014, primarily due to ACA related fees of $97.6 million and the $141.4 million health insurer fee. Our G&A expenses in 2014 also included $96.8 million of expenses primarily related to the Cognizant Transaction (see "—Cognizant Transaction" and Note 3 to our consolidated financial statements).

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

On April 1, 2012, we completed the sale of our Medicare PDP business to CVS Caremark. See Note 3 to our consolidated financial statements for more information. As a result of the sale, our results of operations for the year ended December 31, 2012 included loss from discontinued operation of $(18.5) million related to our Medicare PDP business. Additionally, as a result of this sale, we recorded a gain on sale of discontinued operation in the amount of $132.8 million pretax, or $114.8 million after-tax, in the year ended December 31, 2012. As of December 31, 2013 and 2012, respectively, we had no Medicare stand-alone prescription drug plan members.

In the year ended December 31, 2013, we reported net income of $170.1 million or $2.12 per diluted share as compared to net income of $122.1 million or $1.47 per diluted share for the same period in 2012. For the year ended December 31, 2013, we reported net income from continuing operations of $170.1 million or $2.12 per diluted share as compared to net income from continuing operations of $25.7 million or $0.31 per diluted share for the same period in 2012. Pretax margin from continuing operations was 2.4 percent for 2013 compared to 0.3 percent for 2012.

Our total revenues decreased 2.1 percent in the year ended December 31, 2013 to $11.1 billion from $11.3 billion in the same period in 2012. Health plan services premiums revenues decreased to $10.4 billion in the year ended December 31, 2013, compared with $10.5 billion in the year ended December 31, 2012. Health plan services expenses decreased by 4.6 percent from $9.3 billion in the year ended December 31, 2012 to $8.9 billion in the year ended December 31, 2013. Investment income decreased to $69.6 million in the year ended December 31, 2013 compared with $82.4 million in the year ended December 31, 2012.

Our government contracts revenues decreased by 17.0 percent in 2013 to $0.6 billion from $0.7 billion in 2012. Our government contracts costs decreased by 16.9 percent in 2013 to $0.5 billion from $0.6 billion in 2012. The declines in our government contracts revenues and costs were primarily due to the terms and structure of the MFLC contract we entered into in August 2012, as compared to the prior MFLC contract.

Our operating results for the year ended December 31, 2012 were impacted by approximately $34.5 million of negative prior period reserve development. This negative prior period reserve development was recorded as part of health care costs. For the year ended December 31, 2013, we had approximately $56.2 million in favorable reserve developments related to prior years. The reserve developments related to prior years when considered together with the provision for adverse deviation recorded as of December 31, 2013, did not have a material impact on our operating results or financial condition. Our operating results for the year ended December 31, 2013 were impacted by $12.0 million in pretax costs primarily related to our continuing efforts to address scale issues. Our operating results for the year ended December 31, 2012 were impacted by pretax costs of $35.6 million related to our G&A cost reduction efforts, $5.0 million related to the early termination of a medical management contract and $1.3 million in litigation-related expenses net of an insurance reimbursement.

Days Claims Payable

Days claims payable ("DCP") for the year ended December 31, 2014 was 61.2 days compared with 40.4 days for the year ended December 31, 2013. Adjusted DCP, which we calculate in accordance with the paragraph below, for the year ended December 31, 2014 was 77.2 days compared with 58.7 days for the year ended December 31, 2013. The year over year increase was primarily due to the impact of the reinsurance recoverable that reduced commercial health plan services costs, as well as higher reserves that resulted from our significant enrollment growth during 2014.

Set forth below is a reconciliation of adjusted DCP, a non-GAAP financial measure, to the comparable GAAP financial measure, DCP. DCP is calculated by dividing the amount of reserve for claims and other settlements ("Claims Reserve") by health plan services cost ("Health Plan Costs") during the year and multiplying that amount by the number of days in the year. In this Annual Report on Form 10-K, the following table presents an adjusted DCP metric that subtracts capitation, provider and other claim settlements and Medicare Advantage Prescription Drug ("MAPD") payables/costs from the Claims Reserve and Health Plan Costs. Management believes that adjusted DCP provides useful information to investors because the adjusted DCP calculation excludes from both Claims Reserve and Health Plan Costs amounts related to health care costs for which no or minimal reserves are maintained. Therefore, management believes that adjusted DCP may present a more accurate reflection of DCP than does GAAP DCP, which includes such amounts. This non-GAAP financial information should be considered in addition to, not as a substitute for, financial information prepared in accordance with GAAP. You are encouraged to evaluate these adjustments and the reasons we consider them appropriate for supplemental analysis. In evaluating the adjusted amounts, you should be aware that we have incurred expenses that are the same as or similar to some of the adjustments in the current presentation and we may incur them again in the future. Our presentation of the adjusted amounts should not be construed as an inference that our future results will be unaffected by unusual or nonrecurring items.

	Year Ended December 31,	
	2014	2013
	(Dollars in millions)	
Reconciliation of Adjusted Days Claims Payable:		
(1) Reserve for Claims and Other Settlements—GAAP	$ 1,896.0	$ 984.1
Less: Capitation, Provider and Other Claim Settlements and MAPD Payables	(467.2)	(93.9)
(2) Reserve for Claims and Other Settlements—Adjusted	$ 1,428.8	$ 890.2
(3) Health Plan Services Cost—GAAP	$ 11,307.8	$ 8,886.5
Less: Capitation, Provider and Other Claim Settlements and MAPD Costs	(4,553.7)	(3,348.9)
(4) Health Plan Services Cost—Adjusted	$ 6,754.1	$ 5,537.6
(5) Number of Days in Period	365	365
(1) / (3) * (5) Days Claims Payable—GAAP (using end of period reserve amount)	61.2	40.4
(2) / (4) * (5) Days Claims Payable—Adjusted (using end of period reserve amount)	77.2	58.7

Income Tax Provision

Our income tax expense (benefit) and the effective income tax rate for the years ended December 31, 2014, 2013 and 2012 are as follows:

	2014	2013	2012
	(Dollars in millions)		
Continuing Operations:			
Income tax expense from continuing operations	$ 54.2	$ 99.8	$ 6.0
Effective income tax rate for continuing operations	27.1%	37.0%	18.9%
Discontinued Operations:			
Income tax benefit from discontinued operation [A]			$ (10.3)
Effective income tax rate for discontinued operation [A]			35.8%
Income tax expense from gain on sale of discontinued operation [B]			$ 18.0
Effective income tax rate for gain on sale of discontinued operation [B]			13.5%

A - For the years ended December 31, 2014 and 2013, we had no discontinued operations; therefore, income tax expense from discontinued operation and the corresponding effective income tax rate are not applicable.

B - For the years ended December 31, 2014 and 2013, we had no sale of a discontinued operation; therefore, income tax expense from gain on sale of discontinued operation and the corresponding effective income tax rate are not applicable.

Continuing Operations

The effective income tax rate for continuing operations was 27.1% and 37.0% for the years ended December 31, 2014 and 2013, respectively. For the year ended December 31, 2014, our effective tax rate was adversely impacted by the health insurer fee required by the ACA. The $141.4 million that we paid in 2014 for the health insurer fee is not deductible for federal income tax purposes and in many state jurisdictions. The non-deductible health insurer fee increased our effective tax rate for the year ended December 31, 2014 by 24.8 percentage points. In addition, we incurred a Section 165(g) loss on the stock of one of our subsidiaries that created a tax benefit during the period of $73.7 million, net of adjustments to our reserve for uncertain tax benefits. This tax benefit was primarily responsible for reducing our effective tax rate below the statutory federal tax rate of 35% for the year ended December 31, 2014. Other items which caused our effective income tax rate to differ from the statutory federal tax rate of 35% for the year ended December 31, 2014 include state income taxes, tax-exempt interest, and non-deductible compensation. See Note 11 to our consolidated financial statements for additional information. The effective income tax rate was higher than the statutory federal tax rate of 35% for the year ended December 31, 2013 primarily due to state income taxes, tax-exempt investment income, and non-deductible compensation. Our tax rate for the year ended December 31, 2012 was lower than the statutory federal rate of 35% primarily due to the effect of tax-exempt income and reductions of valuation allowances against deferred assets, which resulted from the utilization of capital loss carryforwards against gains on sale of marketable securities. Such beneficial impacts were partially offset by the effect of certain compensation treated as non-deductible under the ACA. In all periods presented, our effective income tax rate has not been impacted by operations in foreign jurisdictions with varying statutory tax rates. Our health care operations are almost entirely domestic. In 2015, we expect our effective income tax rate will exceed 50% as a result of the non-deductibility of the health insurer fee under the ACA.

Discontinued Operations

For the year ended December 31, 2012, we recorded tax expense of $18.0 million net against the gain on sale of discontinued operation. See Note 3 to our consolidated financial statements for additional information regarding the sale of our Medicare PDP business. An effective tax rate was only applicable to the year ended December 31, 2012 because that is the only period for which a gain on sale of discontinued operation was recorded. The effective tax rate differs from the federal statutory rate of 35% due primarily to the impact of nondeductible goodwill impairment and a reduction in the valuation allowance against deferred tax assets, which resulted from the utilization of capital loss carryforwards against the gain on the sale of our Medicare PDP business.

Also in connection with the sale of our Medicare PDP business, we classified the operating results of our Medicare PDP business as discontinued operation. We recorded tax benefits of $10.3 million against losses from discontinued operation for the year ended December 31, 2012. The effective income tax rate related to loss from discontinued operation for the year ended December 31, 2012 was slightly above the federal statutory tax rate of 35% due to state income taxes. The effective income tax rate on the gain on sale of discontinued operation varied from the statutory federal rate of 35% for the year ended December 31, 2012 due to state income taxes and the release of a valuation allowance against deferred tax assets for capital loss carryforwards, which were utilized upon the gain on sale of the Medicare PDP business.

Western Region Operations Reportable Segment

Our Western Region Operations segment includes the operations of our commercial, Medicare, Medicaid and dual eligibles health plans, the operations of our health and life insurance companies primarily in California, Arizona, Oregon and Washington, and our pharmaceutical services subsidiary and certain operations of our behavioral health subsidiaries in several states including Arizona, California, Oregon and Washington. Our Western Region Operations segment excludes the operating results of our Medicare PDP business, which had been classified as discontinued operation for the year ended December 31, 2012.

Western Region Operations Segment Membership

	As of December 31,			Change			
				2014 v 2013		2013 v 2012	
	2014	2013	2012	Increase/ (Decrease)	% Change	Increase/ (Decrease)	% Change
	(Membership in thousands)						
California							
Large Group	474	565	696	(91)	(16.1)%	(131)	(18.8)%
Small Group	246	244	248	2	0.8 %	(4)	(1.6)%
Individual	237	100	65	137	137.0 %	35	53.8 %
Commercial	957	909	1,009	48	5.3 %	(100)	(9.9)%
Medicare Advantage	173	153	145	20	13.1 %	8	5.5 %
Medi-Cal/Medicaid	1,595	1,113	1,084	482	43.3 %	29	2.7 %
Dual Eligibles	16			16			
Total California	2,741	2,175	2,238	566	26.0 %	(63)	(2.8)%
Arizona							
Large Group	44	57	82	(13)	(22.8)%	(25)	(30.5)%
Small Group	43	39	44	4	10.3 %	(5)	(11.4)%
Individual	92	12	15	80	666.7 %	(3)	(20.0)%
Commercial	179	108	141	71	65.7 %	(33)	(23.4)%
Medicare Advantage	46	43	43	3	7.0 %	—	— %
Medicaid	81	4		77	1,925.0 %	4	
Total Arizona	306	155	184	151	97.4 %	(29)	(15.8)%
Northwest							
Large Group	29	29	26	—	— %	3	11.5 %
Small Group	24	36	54	(12)	(33.3)%	(18)	(33.3)%
Individual	3	3	3	—	— %	—	— %
Commercial	56	68	83	(12)	(17.6)%	(15)	(18.1)%
Medicare Advantage	56	48	46	8	16.7 %	2	4.3 %
Total Northwest	112	116	129	(4)	(3.4)%	(13)	(10.1)%
Total Health Plan Enrollment							
Large Group	547	651	804	(104)	(16.0)%	(153)	(19.0)%
Small Group	313	319	346	(6)	(1.9)%	(27)	(7.8)%
Individual	332	115	83	217	188.7 %	32	38.6 %
Commercial	1,192	1,085	1,233	107	9.9 %	(148)	(12.0)%
Medicare Advantage	275	244	234	31	12.7 %	10	4.3 %
Medi-Cal/Medicaid	1,676	1,117	1,084	559	50.0 %	33	3.0 %
Dual Eligibles	16			16			
	3,159	2,446	2,551	713	29.1 %	(105)	(4.1)%

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Total Western Region Operations enrollment at December 31, 2014 was approximately 3.2 million members, an increase of 29.1 percent compared with enrollment at December 31, 2013. Total enrollment in our California health plan increased by 26.0 percent to approximately 2.7 million members from December 31, 2013 to December 31, 2014.

Western Region Operations commercial enrollment increased by 9.9 percent from December 31, 2013 to approximately 1.2 million members at December 31, 2014, primarily due to an increase in our individual business as a result of new individual members from the ACA exchanges in California and Arizona, partially offset by declines in large and small group membership.

Enrollment in our large group accounts decreased by 16.0 percent or 104,000 members to 547,000 members, from December 31, 2013 to December 31, 2014, primarily due to increasingly competitive markets in California. Enrollment in our small group business in our Western Region Operations segment decreased by 1.9 percent, from approximately 319,000 members at December 31, 2013 to approximately 313,000 members at December 31, 2014. Enrollment in our individual business in our Western Region Operations segment increased by 188.7 percent, from approximately 115,000 members at December 31, 2013 to approximately 332,000 members at December 31, 2014. This increase was primarily due to an increase in our individual business as a result of new individual members from the ACA exchanges in California and Arizona. As of December 31, 2014, tailored network products accounted for 49.8 percent of our Western Region Operations commercial enrollment compared with 37.5 percent at December 31, 2013. For additional information on our tailored network products, see "Item 1. Business—Segment Information—Western Region Operations Segment—Managed Health Care Operations."

Enrollment in our Medicare Advantage plans in our Western Region Operations at December 31, 2014 was 275,000 members, an increase of 12.7 percent compared with December 31, 2013. The increase in Medicare Advantage membership was due to gains of approximately 20,000 members in California, 8,000 members in the Northwest, and 3,000 members in Arizona. We have exited certain under-performing counties in our Medicare business, and consequently expect lower enrollment in our Medicare Advantage plans in 2015.

Medicaid enrollment in California increased by 482,000 members or 43.3 percent to 1,595,000 members at December 31, 2014 compared with 1,113,000 members at December 31, 2013, primarily as a result of new members added from the expansion of Medicaid eligibility under the ACA to all individuals with incomes up to 133 percent of the Federal Poverty Level. In addition, in October 2013, we began administering Medicaid benefits in Maricopa County, Arizona pursuant to our contract with the Arizona Health Care Cost Containment System ("AHCCCS"). As of December 31, 2014, we had approximately 81,000 Medicaid members in Arizona compared with approximately 4,000 members at December 31, 2013. On February 4, 2015, we received a notice from the AHCCCS Division of Health Care Management that stated that we were in violation of our Medicaid contract in Maricopa County. As a result, we are currently subject to sanctions that include a cap on member auto assignment under the contract effective as of February 13, 2015 until further notice. See "Item 1A. Risk Factors" for additional information on these sanctions.

We are the sole commercial plan contractor with DHCS to provide Medi-Cal services in Los Angeles County, California. As of December 31, 2014, approximately 849,000 of our Medi-Cal members resided in Los Angeles County, representing approximately 53 percent of our Medi-Cal membership. As part of our 2012 state settlement agreement with DHCS, DHCS agreed, among other things, to the extension of all of our existing Medi-Cal managed care contracts, including our contract with DHCS to provide Medi-Cal services in Los Angeles County, for an additional five years from their then existing expiration dates. Accordingly, our Medi-Cal contract for Los Angeles County is scheduled to expire in April 2019. For additional information on our settlement agreement with DHCS, see Note 2 to our consolidated financial statements under the heading "Health Plan Services Revenue Recognition."

As more fully described below, in 2012, the California legislature enacted the Coordinated Care Initiative, or “CCI.” The DHCS selected eight counties to participate in the CCI, including Los Angeles and San Diego counties. In participating counties, the CCI established a voluntary “dual eligibles demonstration,” and in April 2012, DHCS selected us to participate in the dual eligibles demonstration for both Los Angeles and San Diego counties. Active enrollment in Los Angeles and San Diego counties for the dual eligible demonstrations commenced on April 1, 2014. Passive enrollment in San Diego County began on May 1, 2014, and passive enrollment in Los Angeles County began on July 1, 2014. As of December 31, 2014, we had approximately 16,000 dual eligibles members. See "—California Coordinated Care Initiative," below for more information on the CCI and the dual eligibles.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Total Western Region Operations enrollment at December 31, 2013 was approximately 2.4 million members, a decrease of 4.1 percent compared with enrollment at December 31, 2012. Total enrollment in our California health plan decreased by 2.8 percent to approximately 2.2 million members from December 31, 2012 to December 31, 2013.

Western Region Operations commercial enrollment declined by 12.0 percent from December 31, 2012 to approximately 1.1 million members at December 31, 2013, primarily due to increasingly competitive markets and our efforts to reposition our commercial book of business away from unprofitable full network large group accounts towards smaller accounts and tailored network products. Enrollment in our large group accounts decreased by 19.0 percent or 153,000 members to 651,000 members, from December 31, 2012 to December 31, 2013. Enrollment in our small group business in our Western Region Operations segment decreased by 7.8 percent, from approximately 346,000 members at December 31, 2012 to approximately 319,000 members at December 31, 2013. Enrollment in our individual business in our Western Region Operations segment increased by 38.6 percent, from approximately 83,000 members at December 31, 2012 to approximately 115,000 members at December 31, 2013. As of December 31, 2013, tailored network products accounted for 37.5 percent of our Western Region Operations commercial enrollment compared with 35.0 percent at December 31, 2012.

Enrollment in our Medicare Advantage plans in our Western Region Operations at December 31, 2013 was 244,000 members, an increase of 4.3 percent compared with December 31, 2012. The increase in Medicare Advantage membership was due to gains of approximately 8,000 members in California and 2,000 members in the Northwest.

Medicaid enrollment in California increased by 29,000 members or 2.7 percent to 1,113,000 members at December 31, 2013 compared with 1,084,000 members at December 31, 2012. As of December 31, 2013, we had approximately 4,000 Medicaid members in Arizona.

As of December 31, 2013, approximately 572,000 of our Medi-Cal members resided in Los Angeles County, representing approximately 51 percent of our Medi-Cal membership and approximately 51 percent of our membership in all California state health programs.

California Coordinated Care Initiative

In 2012, the California legislature enacted the CCI. The stated purpose of the CCI is to provide a more efficient health care delivery system and improved coordination of care to individuals that are fully eligible for Medicare and Medi-Cal benefits, or "dual eligibles," as well as to all Medi-Cal only beneficiaries who rely on long-term services and supports, or “LTSS,” which includes institutional long-term care and home and community-based services and other support services.

In participating counties, the CCI established a voluntary “dual eligibles demonstration,” also referred to as the “Cal MediConnect” program, to coordinate medical, behavioral health, long-term institutional, and home- and community-based services for dual eligibles through a single health plan, and will require that all Medi-Cal beneficiaries in participating counties join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS. The DHCS selected eight counties to participate in the CCI, including Los Angeles and San Diego counties. On April 4, 2012, DHCS selected us to participate in the dual eligibles demonstration for both Los Angeles and San Diego counties. In December 2013, Health Net Community Solutions, Inc., our wholly owned subsidiary, entered into a three-way agreement with DHCS and CMS, which was subsequently amended on January 13, 2014 (the “Cal MediConnect Contract”). Among other things, under the Cal MediConnect Contract we have received and expect to continue to receive prospective blended capitated payments to provide coverage for dual eligibles in Los Angeles and San Diego counties. These blended capitated payments are determined based on our mix of membership.

In January 2014, CMS and DHCS informed us that based on its readiness assessments, we were able to enroll members beginning April 1, 2014, and could begin marketing for the dual eligibles demonstration in accordance with the guidelines and time frames for Los Angeles and San Diego counties. Active enrollment in Los Angeles and San Diego counties for the dual eligibles demonstrations commenced on April 1, 2014, and is scheduled to conclude at the end of 2017. During the active enrollment period, dual eligibles in Los Angeles County are able to either choose among us, the local health plan initiative, or one of three other health plans for benefits under the dual eligibles demonstration. On July 1, 2014, DHCS began automatically enrolling dual eligibles in Los Angeles County who have not selected a health plan, which we refer to as “passive enrollment.” Dual eligibles also may choose to “opt out” of the demonstration at any time. Such dual eligibles will then continue to receive fee-for-service Medicare benefits but will receive Medi-Cal benefits through a managed care health plan as required under the CCI. During the active enrollment period in San Diego County, dual eligibles are able to select to receive benefits from any one of four health plan options, including us, or “opt out” of the demonstration. Passive enrollment in San Diego County began on May 1, 2014. Based on our understanding of the passive enrollment methodology, we estimate that Health Net will receive approximately 47% and 20–25% of the passively enrolled dual eligibles in Los Angeles County and San Diego County, respectively.

The financial performance of the Cal MediConnect Contract is included in the calculation of the settlement account that was established pursuant to the terms of the settlement agreement entered into by DHCS, HNCS and Health Net of California, Inc. on November 2, 2012, which is further discussed in Note 2 to our consolidated financial statements under the heading "Health Plan Services Revenue Recognition."

Health Net's participation in the CCI, and the dual eligibles demonstration in particular, represents a significant new business opportunity for us, but is subject to a number of risks inherent in untested health care initiatives, particularly those that involve new populations with limited cost experience. Moreover, the CCI and the dual eligibles demonstration program in particular, is a model of providing health care that is new to regulatory authorities and health plans in the state of California, and involves risks generally associated with government programs. For example, larger than expected numbers of dual eligibles have opted out of the demonstration since passive enrollment began in Los Angeles and San Diego counties on July 1, 2014 and May 1, 2014, respectively, which impacted our expected enrollment for 2014. If this opt out trend continues or significantly increases over the passive enrollment period, our profitability with respect to our participation in the CCI may be lower than originally anticipated. Due to these and other risks associated with the CCI, including, without limitation, that the dual eligibles demonstration is a pilot program, there can be no assurance that the business opportunity presented by the CCI, including the dual eligibles demonstration, will prove to be successful. Our failure to successfully adapt to the requirements of the CCI could have an adverse effect on our business, financial condition and results of operation. For additional information regarding our participation in the duals program see "Item 1. Business—Segment Information—Western Region Operations Segment—California Coordinated Care Initiative" and for a discussion of additional risks related to the duals program, see "Item 1A. Risk Factors—*Our participation in the dual eligibles demonstration portion of the California Coordinated Care Initiative in Los Angeles and San Diego Counties may prove to be unsuccessful for a number of reasons*."

Western Region Operations Segment Results

	Year Ended December 31,		
	2014	2013	2012
	(Dollars in thousands, except PMPM data)		
Commercial premiums	$ 5,443,062	$ 5,175,370	$ 5,705,497
Medicare premiums	3,044,274	2,771,431	2,790,497
Medicaid premiums	4,755,897	2,430,272	1,963,104
Dual Eligibles premiums	117,937	—	—
Health plan services premiums	13,361,170	10,377,073	10,459,098
Net investment income	45,166	69,613	82,434
Administrative services fees and other income	(1,725)	34,791	17,957
Total revenues	13,404,611	10,481,477	10,559,489
Health plan services	11,307,751	8,886,547	9,316,922
Premium tax	191,150	124,360	51,617
Health insurer fee	141,445	—	—
Other ACA fees	97,557	2,530	1,578
Administrative expenses	1,027,718	949,927	849,947
Total general and administrative	1,457,870	1,076,817	903,142
Selling	262,338	239,428	245,925
Depreciation and amortization	29,704	38,589	31,145
Interest	31,376	32,614	33,220
Total expenses	13,089,039	10,273,995	10,530,354
Income from operations before income taxes	315,572	207,482	29,135
Income tax provision	169,340	73,621	(1,034)
Net income	$ 146,232	$ 133,861	$ 30,169
Pretax margin	2.4 %	2.0 %	0.3%
Commercial premium yield	0.1 %	2.7 %	4.7%
Commercial premium PMPM (d)	$ 385.42	$ 385.13	$ 374.99
Commercial health care cost trend	(3.0)%	(1.0)%	9.1%
Commercial health care cost PMPM (d)	$ 319.82	$ 329.75	$ 333.17
Commercial medical care ratio (MCR) (e)	83.0 %	85.6 %	88.8%
Medicare Advantage MCR (e)	91.5 %	90.6 %	89.3%
Medicaid MCR (e)	82.1 %	80.4 %	89.4%
Dual Eligibles MCR (e)	86.1 %		
Health plan services MCR (a)	84.6 %	85.6 %	89.1%
Administrative expense ratio (b)	7.7 %	9.1 %	8.1%
Total G&A expense ratio (b)	10.9 %	10.3 %	8.6%
Selling costs ratio (c)	2.0 %	2.3 %	2.4%

____

(a) Health plan services MCR is calculated as health plan services cost divided by health plan services premiums revenue.

(b) Administrative expense and Total G&A expense ratios are computed as either administrative expenses or total general and administrative expenses divided by the sum of health plan services premiums and administrative services fees and other income.

(c) The selling costs ratio is computed as selling expenses divided by health plan services premiums revenue.

(d) Per member per month ("PMPM") is calculated based on commercial at-risk member months and excludes administrative services only ("ASO") member months.

(e) Commercial, Medicare Advantage, Medicaid or Dual Eligibles MCR is calculated as commercial, Medicare, Medicaid or Dual Eligibles health care cost divided by commercial, Medicare, Medicaid or Dual Eligibles premiums, as applicable.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Revenues

Total revenues in our Western Region Operations segment for the year ended December 31, 2014 increased 27.9 percent to $13.4 billion compared to the same period in 2013 primarily due to an increase in our premium revenues in our health plans. Health plan services premiums revenues in our Western Region Operations segment increased to $13.4 billion for the year ended December 31, 2014 compared to $10.4 billion in the same period in 2013, primarily due to increase in our Medicaid premium revenues.

Our commercial premium revenue increased by $267.7 million, or 5.2 percent, in the year ended December 31, 2014 compared to the same period in 2013, primarily due to a 9.9 percent increase in commercial enrollment since December 31, 2013. The net impact of amounts recorded under the ACA's premium stabilization provisions on our commercial premium revenue in 2014 was not material. See "—Liquidity and Capital Resources—Liquidity" and Note 2 to our consolidated financial statements under the heading "Accounting for Certain Provisions of the ACA" for more information.

Our Medicare premium revenue increased by $272.8 million, or 9.8 percent, in the year ended December 31, 2014 compared to the same period in 2013, primarily due to a 12.7 percent increase in Medicare Advantage enrollment since December 31, 2013.

Our Medicaid premium revenue increased by $2.3 billion, or 95.7 percent, in the year ended December 31, 2014 compared to the same period in 2013, primarily due to significant membership growth related to Medicaid expansion under the ACA during the year ended December 31, 2014. As of December 31, 2014, we accrued $200.6 million for an MLR rebate payable to DHCS in connection with Medicaid adult expansion members and accrued $24.7 million, net of $2.3 million receivable, for excess profit sharing payable to the state of Arizona under our Arizona Medicaid contract. Accordingly, Medicaid premium revenue was reduced by $225.3 million for the year ended December 31, 2014 related to MLR rebates. (see Note 2 to our consolidated financial statements, under the heading "Health Plan Services Revenue Recognition" for more information).

Active enrollment in Los Angeles and San Diego counties for the dual eligibles demonstrations began on April 1, 2014, and passive enrollment began on July 1, 2014 and May 1, 2014 for Los Angeles County and San Diego County, respectively. As of December 31, 2014, we had approximately 16,000 dual eligible members and for the year ended December 31, 2014, our dual eligibles premium revenues were $117.9 million. See "—California Coordinated Care Initiative," above for more information on the CCI and the dual eligibles.

Investment income in our Western Region Operations segment decreased to $45.2 million for the year ended December 31, 2014 from $69.6 million for the same period in 2013 due to lower investment gains realized during the year ended December 31, 2014.

Administrative services fees and other income decreased by $36.5 million for the year ended December 31, 2014 as compared to the year ended December 31, 2013, primarily due to a settlement related to a pharmacy contract in 2013 and the change in the reimbursement methodology of Section 1202 of the ACA in 2014.

Health Plan Services Expenses

Health plan services expenses in our Western Region Operations segment increased 27.2 percent to approximately $11.3 billion for the year ended December 31, 2014 from approximately $8.9 billion for the year ended December 31, 2013, primarily due to new membership resulting from Medicaid expansion under the ACA, partially offset by $234.0 million of reinsurance recoverable included in commercial health plan services costs for the year ended December 31, 2014, as discussed in Note 2 to our consolidated financial statements under the heading "Accounting for Certain Provisions of the ACA."

Commercial Premium Yield and Health Care Cost Trends

In our Western Region Operations segment, commercial premium PMPM increased by 0.1 percent to approximately $385 for the year ended December 31, 2014 compared to an increase of 2.7 percent to approximately $385 in the same period of 2013.

Commercial health care costs PMPM in our Western Region Operations segment decreased by 3.0 percent to approximately $320 in the year ended December 31, 2014 compared to a decrease of 1.0 percent to approximately $330 in the year ended December 31, 2013. We believe that the decrease in our commercial health care cost trend for the year ended December 31, 2014 was primarily due to the mix shift in the makeup of our commercial membership with significantly higher individual membership in 2014 compared to 2013, combined with moderate health care cost trends for the commercial market as a whole in 2014.

Medical Care Ratios

The health plan services MCR in our Western Region Operations segment was 84.6 percent for the year ended December 31, 2014 compared with 85.6 percent for the year ended December 31, 2013.

The commercial MCR in our Western Region Operations segment was 83.0 percent for the year ended December 31, 2014 compared with 85.6 percent for the year ended December 31, 2013. The improvement of 260 basis points in the commercial MCR for the year ended December 31, 2014 compared to the same period in 2013 was primarily due to better performance in our group accounts that allowed us to absorb the impact of the health insurer fee, a higher percentage of individual enrollment in our membership mix, and moderate health care cost trends.

The Medicare Advantage MCR in our Western Region Operations segment was 91.5 percent for the year ended December 31, 2014 compared with 90.6 percent for the year ended December 31, 2013. The Medicare Advantage MCR increased by 90 basis points for the year ended December 31, 2014 compared to the same period in 2013, primarily due to higher utilization from Medicare Advantage members who changed health plans at year-end and from the impact of an earlier than expected flu season in this population.

The Medicaid MCR in our Western Region Operations segment was 82.1 percent for the year ended December 31, 2014 compared with 80.4 percent for the year ended December 31, 2013. The Medicaid MCR increased by approximately 170 basis points for the year ended December 31, 2014 compared to the same period in 2013. The increase in the Medicaid MCR was primarily due to the impact of MLR rebate accruals in 2014 combined with the following factors, which benefited the Medicaid MCR in the year ended December 31, 2013: a favorable impact from both Medicaid rate adjustments and reinstated Medicaid premium taxes, including portions that are retroactive, and retrospective adjustments to premium revenues as a result of our settlement agreement with DHCS.

The dual eligibles MCR in our Western Region Operations segment was 86.1 percent for the year ended December 31, 2014. Active enrollment under the Dual Eligibles program began for the first time in the second quarter of 2014.

General and Administrative, Selling and Interest Expenses

Total general and administrative expense in our Western Region Operations segment was $1.5 billion for the year ended December 31, 2014 compared with $1.1 billion for the year ended December 31, 2013. The total G&A expense ratio was 10.9 percent for the year ended December 31, 2014 compared with 10.3 percent for the year ended December 31, 2013. The increase in our total general and administrative expenses for the year ended December 31, 2014 was primarily due to increases in premium taxes and ACA-related fees, including the health insurer fee. Such increases in premium taxes and ACA-related fees increased the total G&A expense ratio by approximately 200 basis points for the year ended December 31, 2014 as compared to the prior year. See Note 2 to our consolidated financial statements, under the heading "Accounting for Certain Provisions of the ACA" for more information regarding ACA-related fees.

Selling expense in our Western Region Operations segment was $262.3 million for the year ended December 31, 2014 compared with $239.4 million for the year ended December 31, 2013. The selling costs ratio was 2.0 percent for the year ended December 31, 2014 compared with 2.3 percent for the year ended December 31, 2013. This decrease in our selling costs ratio was primarily due to the change in the mix of our business from the impact of ACA and state exchanges.

Interest expense in our Western Region Operations segment decreased to $31.4 million for the year ended December 31, 2013 from $32.6 million for the year ended December 31, 2013 primarily due to lower interest rates.

Year Ended December 31, 2013 compared to Year Ended December 31, 2012

Revenues

Total revenues in our Western Region Operations segment for the year ended December 31, 2013 decreased 0.7 percent to $10.5 billion compared to the same period in 2012 primarily due to a decrease in our premium revenues in our health plans. Health plan services premiums revenues in our Western Region Operations segment decreased to $10.4 billion for the year ended December 31, 2013 from $10.5 billion in the same period in 2012, primarily due to a decrease in commercial premium revenues, partially offset by an increase in Medicaid premium revenues.

Our commercial premium revenue decreased by $530.1 million, or 9 percent, in the year ended December 31, 2013 compared to the same period in 2012, primarily due to a 12 percent decrease in commercial enrollment.

Our Medicare premium revenue decreased by $19.1 million, or 0.7 percent, in the year ended December 31, 2013 compared to the same period in 2012, primarily due to federal rate decreases.

Our Medicaid premium revenue increased by $467.2 million, or 24 percent, in the year ended December 31, 2013 compared to the same period in 2012, primarily due to premium rate increases, reinstated Medicaid premium taxes, accruals made pursuant to our state settlement agreement, membership growth and the rollout of a new Medicaid service, Community Based Adult Services, some of which are further discussed below. The increase in our Medicaid premium revenue for the year ended December 31, 2013 included $74.3 million of retroactive rate adjustments for our SPD and non-SPD members for periods prior to 2013. For the year ended December 31, 2012, we recognized $21.7 million of premium revenue as a result of retroactive rate adjustments for our SPD and non-SPD members for periods prior to 2012. The increase in our Medicaid premium revenue for the year ended December 31, 2013 also included $92.8 million in Medicaid premium revenues related to reinstated premium taxes for the year ended December 31, 2013. See Note 2 to our consolidated financial statements under the headings "Health Plan Services Revenue Recognition" and "Medicaid Premium Taxes" for additional information. Medicaid premium revenue for the year ended December 31, 2013 also included $62.9 million of retrospective adjustments to premium revenue related to our state-sponsored health plans rate settlement agreement as described in Note 2 to our consolidated financial statements under the heading "Health Plan Services Revenue Recognition."

Investment income in our Western Region Operations segment decreased to $69.6 million for the year ended December 31, 2013 from $82.4 million for the same period in 2012 due to lower investment gains realized during the year ended December 31, 2013 as compared to 2012.

Administrative services fees and other income increased by $16.8 million for the year ended December 31, 2013 as compared to the year ended December 31, 2012 primarily due to a settlement related to a pharmacy contract and Medicaid revenue from the State of California related to the administration of the primary care physician parity reimbursement mandated by the ACA.

Health Plan Services Expenses

Health plan services expenses in our Western Region Operations segment decreased 4.6 percent to approximately $8.9 billion for the year ended December 31, 2013 from approximately $9.3 billion for the year ended December 31, 2012, primarily due to a decrease in commercial health plan services costs, partially offset by an increase in Medicaid health plan services costs as discussed in the following sections.

Commercial Premium Yield and Health Care Cost Trends

In our Western Region Operations segment, commercial premium PMPM increased by 2.7 percent to approximately $385 for the year ended December 31, 2013 compared to an increase of 4.7 percent to approximately $375 in the same period of 2012. This percentage change decrease in the 2013 premium yield compared to that in 2012 was due to changes in geographic and product mix, including a higher percentage of members enrolled in our tailored network products.

Commercial health care costs PMPM in our Western Region Operations segment decreased by 1.0 percent to approximately $330 in the year ended December 31, 2013 compared to an increase of 9.1 percent to approximately $333 in the year ended December 31, 2012. We believe that the decrease in our commercial health care cost trend for the year ended December 31, 2013 was due to the absence of adverse prior period development and our efforts to reposition our commercial book of business away from unprofitable full network large group accounts towards smaller accounts and tailored network products.

Medical Care Ratios

The health plan services MCR in our Western Region Operations segment was 85.6 percent for the year ended December 31, 2013 compared with 89.1 percent for the year ended December 31, 2012.

Commercial MCR in our Western Region Operations segment was 85.6 percent for the year ended December 31, 2013 compared with 88.8 percent for the year ended December 31, 2012. The improvement of 320 basis points in commercial MCR for the year ended December 31, 2013 compared to the same period in 2012 is primarily due to the repositioning of our large group commercial business, lower utilization and changes in product and geographic mix as well as the absence of the adverse prior period development that was recorded in 2012.

The Medicare Advantage MCR in in our Western Region Operations segment was 90.6 percent for the year ended December 31, 2013 compared with 89.3 percent for the year ended December 31, 2012. The Medicare Advantage MCR deteriorated by 130 basis points for the year ended December 31, 2013 compared to the same period in 2012 primarily due to lower premium yield from lower federal rates.

The Medicaid MCR was 80.4 percent for the year ended December 31, 2013 compared with 89.4 percent for the year ended December 31, 2012. The improvement in the Medicaid MCR for the year ended December 31, 2013 compared to the same period in 2012 was primarily due to favorable California Medicaid rate adjustments primarily related to prior periods, the impact of the reinstated Medicaid premium taxes that increased our Medicaid premium revenues, and retrospective adjustments to premium revenues related to our state-sponsored health plans rate settlement agreement. For additional information on the reinstated Medicaid premium taxes and state-sponsored health plans rate settlement agreement, see Note 2 to our consolidated financial statements.

General and Administrative, Selling and Interest Expenses

Total general and administrative expense in our Western Region Operations segment was $1.1 billion for the year ended December 31, 2013 compared with $903.1 million for the year ended December 31, 2012. The total G&A expense ratio was 10.3 percent for the year ended December 31, 2013 compared with 8.6 percent for the year ended December 31, 2012.

Increases in our total general and administrative expenses for the year ended December 31, 2013 were primarily due to increases in insurance, taxes and related fees, including reinstated Medicaid premium taxes of $92.8 million. See Note 2 to our consolidated financial statements for additional information regarding these premium taxes. Such increases in insurance, taxes and related fees impacted the total G&A expense ratio by 140 basis points for the year ended December 31, 2013. In addition, increases in our total general and administrative expenses for the year ended December 31, 2013 were impacted by costs related to the implementation of the CCI, including the dual eligibles demonstration, and the ACA, including the exchanges.

Selling expense in our Western Region Operations segment was $239.4 million for the year ended December 31, 2013 compared with $245.9 million for the year ended December 31, 2012. The selling costs ratio was 2.3 percent for the year ended December 31, 2013 compared with 2.4 percent for the year ended December 31, 2012.

Interest expense in our Western Region Operations segment was $32.6 million for the year ended December 31, 2013 compared with $33.2 million for the year ended December 31, 2012.

Government Contracts Reportable Segment

On April 1, 2011, we began delivery of administrative services under our T-3 contract. The T-3 contract was awarded to us on May 13, 2010, and included five one-year option periods. On March 15, 2014, the Department of Defense exercised the last of these options, which extended the T-3 contract through March 31, 2015. On June 27, 2014, at the Department of Defense's request, we submitted a proposal to add three additional one-year option periods to the T-3 contract. We currently expect negotiations relating to this proposal to conclude on or prior to March 31, 2015. If the negotiations conclude as expected, we expect the DoD to exercise the first of the three one-year options by that date. If all three one-year option periods are ultimately exercised, the T-3 contract would conclude on March 31, 2018. The DoD intends to re-procure managed care support services for the TRICARE program for the period beginning in 2017, and, to that end, released a draft Request for Proposals on November 3, 2014.

Under the T-3 contract for the TRICARE North Region, we provided administrative services to approximately 2.8 million MHS eligible beneficiaries as of December 31, 2014. For a description of the T-3 contract, see "—Overview—How We Measure Our Profitability," and Note 2 to our consolidated financial statements under the heading “Government Contracts” for additional information.

On August 15, 2012, our wholly owned subsidiary, MHN Government Services, Inc. entered into a new contract to provide counseling services to military service members and their families under the MFLC program with a five-year term that includes a 12-month base period and four 12-month option periods. MHN Government Services, Inc. is one of three contractors selected to participate in the MFLC program under the MFLC contract. Revenues from the MFLC contracts were $119.7 million, $104.8 million and $221.3 million for the years ended December 31, 2014, 2013 and 2012, respectively.

In September 2013, VA awarded us a contract under its new PC3 Program. The PC3 Program provides eligible veterans coordinated, timely access to care through a comprehensive network of non-VA providers who meet VA quality standards when a local VA medical center cannot readily provide the care. We support VA in providing care to veterans in three of the six PC3 Program regions. These three regions, Regions 1, 2 and 4, encompass all or portions of 37 states, the District of Columbia, Puerto Rico and the Virgin Islands. The PC3 Program contract term includes a base period of performance through September 30, 2014 and four one-year option periods that may be exercised by VA. On September 23, 2014, the VA exercised option period 1 which commenced on October 1, 2014 and is scheduled to end on September 30, 2015. In addition to the one-year option periods, VA will have the ability to extend the PC3 Program contract an additional two years and six months based on VA's need. In August 2014, VA expanded our PC3 Program contract to include primary care services for veterans who are unable to obtain primary care at a VA medical center in the three PC3 regions in which we operate. In addition, in November 2014, we modified our PC3 Program contract to further expand our services with VA in support of the Veterans Access, Choice and Accountability Act of 2014 ("VACAA"). The VACAA modification to our PC3 contract expires no later than September 30, 2017. See Note 2 to our consolidated financial statements under the heading “Government Contracts” for additional information. For the year ended December 31, 2014, we had $24.7 million in revenues from the PC3 Program.

In addition, we administer contracts with VA to manage community-based outpatient clinics in one state covering approximately 3,696 enrollees.

Government Contracts Segment Membership

	2014	2013	2012
	(Membership in thousands)		
Membership under T-3 TRICARE contract	2,837	2,851	2,883

Under the T-3 contract for the TRICARE North Region, we provide administrative services to approximately 2.8 million, 2.9 million and 2.9 million MHS eligible beneficiaries as of December 31, 2014, 2013 and 2012, respectively.

Government Contracts Segment Results

The following table summarizes the operating results for the Government Contracts segment for the last three fiscal years:

	Year Ended December 31,		
	2014	**2013**	**2012**
	(Dollars in thousands)		
Government contracts revenues	$ 603,975	$ 572,266	$ 689,121
Government contracts costs	534,442	497,780	599,211
Income from continuing operations before income taxes	69,533	74,486	89,910
Income tax provision	28,256	30,900	35,777
Income from continuing operations	$ 41,277	$ 43,586	$ 54,133

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Government contracts revenues increased by $31.7 million, or 5.5 percent, for the year ended December 31, 2014 as compared to the same period in 2013. Government contracts costs increased by $36.7 million or 7.4 percent for the year ended December 31, 2014 as compared to the same period in 2013. The increases in government contracts revenues and costs for the year ended December 31, 2014 were primarily due to services provided under the PC3 Program and due to growth in our MFLC program.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Government contracts revenues decreased by $116.9 million, or 17.0 percent, for the year ended December 31, 2013 as compared to the same period in 2012. Government contracts costs decreased by $101.4 million or 16.9 percent for the year ended December 31, 2013 as compared to the same period in 2012. These declines were primarily due to the terms and structure of the MFLC contract entered into in August 2012, as compared to the prior MFLC contract.

Divested Operations and Services Reportable Segment Results

Our Divested Operations and Services reportable segment was closed out effective January 1, 2013 as discussed below.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Our Divested Operations and Services reportable segment included operations of our businesses that provided administrative and run-out support services in connection with the Northeast Sale and the transition-related revenues and expenses of our Medicare PDP business that was sold on April 1, 2012. As of December 31, 2012, we had substantially completed the administration and run-out of both of our divested businesses. See Notes 3 and 14 to our consolidated financial statements for additional information regarding the sale of our Medicare PDP business and the Northeast Sale, and for more information regarding our reportable segments, respectively.

For the year ended December 31, 2012, we had total revenues of $40.5 million and net loss from continuing operations of $(27.6) million.

In connection with the sale of our Medicare PDP business, we provided Medicare PDP transition-related services to CVS Caremark during the year ended December 31, 2012. Revenues and expenses associated with providing transition-related services to CVS Caremark were $40.5 million and $33.4 million, respectively, for the year ended December 31, 2012.

On July 1, 2011, the United Administrative Services Agreements terminated and we entered into Claims Servicing Agreements pursuant to which we adjudicate run out claims and provide limited other administrative services to United and its affiliates. The revenues and expenses associated with providing services under the Claims Servicing Agreements were $0 and $52.4 million, respectively, for the year ended December 31, 2012. Our operating results for the year ended December 31, 2012 were impacted by $7.4 million in lease impairment costs related to our divested Northeast business and were included in the expenses associated with providing services under the Claims Servicing Agreements.

Corporate/Other

The following table summarizes the Corporate/Other segment for the years ended December 31, 2014, 2013 and 2012:

	Year Ended December 31,		
	2014	2013	2012
	(Dollars in thousands)		
Costs included in health plan services costs	$ —	$ —	$ (783)
Costs included in government contract costs	2,201	5,138	5,863
Costs included in G&A	94,494	6,877	36,892
Depreciation and amortization	82	—	—
Asset impairment	88,536	—	—
Loss from continuing operations before income taxes	(185,313)	(12,015)	(41,972)
Income tax benefit	(143,433)	(4,694)	(10,916)
Loss from continuing operations	$ (41,880)	$ (7,321)	$ (31,056)

Our Corporate/Other segment is not a business operating segment. It is added to our reportable segments to reconcile to our consolidated results. The Corporate/Other segment includes costs that are excluded from the calculation of segment pretax income because they are not managed within the reportable segments.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Our operating results in our Corporate/Other segment for the year ended December 31, 2014 were impacted by an $88.5 million pretax asset impairment primarily related to our assets held for sale in connection with the Cognizant Transaction. See Note 3 to our consolidated financial statements and "—Cognizant Transaction" for additional information regarding assets held for sale and the Cognizant Transaction. In addition, our operating results in our Corporate/Other segment for the year ended December 31, 2014 were impacted by $74.8 million in pretax expenses related to the Cognizant Transaction. Our operating results in our Corporate/Other segment for the year ended

December 31, 2014 were also impacted by a loss on the stock of one of our subsidiaries that created a tax benefit of $73.7 million, net of adjustments to our reserve for uncertain tax benefits. See Note 11 to our consolidated financial statements for additional information regarding this tax benefit.

The operating results in our Corporate/Other segment for the year ended December 31, 2013 were impacted by $12.0 million in pretax costs, primarily severance expenses related to our continuing efforts to address scale issues.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

The operating results in our Corporate/Other segment for the year ended December 31, 2013 were impacted by $12.0 million in pretax costs, primarily severance expenses related to our continuing efforts to address scale issues. Our operating results for the year ended December 31, 2012 were impacted primarily by $35.6 million in pretax costs related to our G&A cost reduction efforts, $1.3 million in pretax litigation-related expenses net of insurance recoveries and $5.0 million in pretax costs related to early termination of a medical management contract.

LIQUIDITY AND CAPITAL RESOURCES

Liquidity

Our primary sources of cash include receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities and borrowings. We believe that expected cash flow from operating activities, existing cash reserves and other working capital and lines of credit are adequate to allow us to fund existing obligations, repurchase shares of our common stock, introduce new products and services, enter into new lines of business and continue to operate and develop health care-related businesses as we may determine to be appropriate at least for the next 12 months. We regularly evaluate cash requirements for, among other things, current operations and commitments, for acquisitions and other strategic transactions, to address legislative or regulatory changes such as the ACA, and for business expansion opportunities, such as the CCI, Medicaid expansion under the ACA and our participation in Arizona's Medicaid program in Maricopa County. We may elect to raise additional funds for these and other purposes, either through issuance of debt or equity, the sale of investment securities or otherwise, as appropriate. Based on the composition and quality of our investment portfolio, our expected ability to liquidate our investment portfolio as needed, and our expected operating and financing cash flows, we do not anticipate any liquidity constraints in the near term. However, turbulence in U.S. and international markets and certain costs associated with health care reform legislation and its implementation, our participation in the CCI, Medicaid expansion under the ACA and our preparation for the Cognizant Transaction, among other things, could adversely affect our liquidity. In addition, as a holding company, our subsidiaries conduct substantially all of our consolidated operations and own substantially all of our consolidated assets. Consequently, our cash flow and our ability to pay our debt depends, in part, on the amount of cash that we receive from our subsidiaries. We are dependent upon dividends and management fees from our regulated subsidiaries, most of which are subject to regulatory restrictions. For a discussion of these and other risks that impact our liquidity, see "Item 1A. Risk Factors."

Our cash flow from operating activities is impacted by, among other things, the timing of collections on our amounts receivable from state and federal governments and agencies. For example, our receivable from DHCS and AHCCCS related to our California and Arizona Medicaid businesses totaled $801.7 million as of December 31, 2014 and $270.9 million as of December 31, 2013. The receivable from CMS related to our Medicare business was $119.1 million as of December 31, 2014 and $105.2 million as of December 31, 2013. Our Government Contracts receivable, including receivables from the DoD relating to our current and prior contracts for the TRICARE North Region, was $150.5 million and $194.0 million as of December 31, 2014 and December 31, 2013, respectively. The timing of collection of such receivables from the federal and state governments and agencies is impacted by government audits as well as government appropriations, allocation and funding processes, among other things, and can extend for periods beyond a year.

In addition, we believe that our cash flow in 2014 was impacted, among other things, by the timing of payments related to the ACA. The largest of the ACA taxes and fees is the health insurer fee. Our allocable share of the 2014 health insurer fee, based upon 2013 premiums, was $141.4 million. We paid that amount in September 2014, which impacted our cash flow from operations for the year ended December 31, 2014. Our cash flow was also impacted by the determination and settlement of amounts related to the premium stabilization provisions in the ACA. Our receivable balance for the reinsurance program related to the premium stabilization provisions of the ACA was $234.0 million as of December 31, 2014. If the per capita premiums/contributions paid by all insurers, including self-funded plans, are insufficient to fund all recoverable amounts, then this will result in pro-rata reduction of recoverable amounts for insurers for the following year. Our net receivable balance for the risk corridor program related to the premium stabilization provisions of the ACA was $86.8 million as of December 31, 2014. HHS recognizes, in both final regulations and guidance, it is obligated to make the risk corridors program payments without regard to budget neutrality. Although HHS anticipates the program will be budget neutral, the ACA requires HHS to make full payments to those issuers with risk corridors ratios above 103 percent. Additionally, HHS states in final regulations and guidance that if the program's collections, including any potential carryover from prior years, are insufficient to satisfy its payment obligations, the agency will use other sources of funding to meet its payment obligations, subject to the availability of appropriations. If corridor collections are insufficient in 2014, HHS explains that it shall fulfill its obligations for the 2014 benefit year by using funds collected for the 2015 benefit year prior to making payments on 2015 obligations. Our net payable balance for the risk adjustment program related to the premium stabilization provisions of the ACA was $72.4 million as of December 31, 2014. The final determination and settlement of amounts due or payable from these premium stabilization provisions for the year ended December 31, 2014 is not expected to occur until, at the earliest, the third or fourth quarter of 2015. See Note 2 to our consolidated financial statements, under the heading "Accounting for Certain Provisions of the ACA" for additional information regarding ACA-related fees and premium stabilization provisions. Depending on the amounts due or payable as a result of these provisions, our financial condition, cash flows and results of operations could be materially adversely affected.

Cash and Investments

As of December 31, 2014, the fair value of our investment securities available-for-sale was $1.8 billion, which includes both current and noncurrent investments. Noncurrent investments were $4.6 million as of December 31, 2014. We hold high-quality fixed income securities primarily comprised of corporate bonds, asset-backed securities, mortgaged-backed bonds, municipal bonds and bank loans. We evaluate and determine the classification of our investments based on management's intent. We also closely monitor the fair values of our investment holdings and regularly evaluate them for other-than-temporary impairments.

Our cash flow from investing activities is primarily impacted by the sales, maturities and purchases of our available-for-sale investment securities and restricted investments. Our investment objective is to maintain safety and preservation of principal by investing in a diversified mix of high-quality fixed-income securities, which are largely investment grade, while maintaining liquidity in each portfolio sufficient to meet our cash flow requirements and attaining an expected total return on invested funds.

Our investment holdings are currently primarily comprised of investment grade securities with an average rating of “A+” and “A1” as rated by S&P and/or Moody's, respectively. At this time, there is no indication of default on interest and/or principal payments under our holdings. We have the ability and current intent to hold to recovery all securities with an unrealized loss position. As of December 31, 2014, our investment portfolio includes $438.5 million, or 24.4% of our portfolio holdings, of mortgage-backed and asset-backed securities. The majority of our mortgage-backed securities are Fannie Mae, Freddie Mac and Ginnie Mae issues, and the average rating of our entire asset-backed securities is AA+/Aa1. However, any failure by Fannie Mae or Freddie Mac to honor the obligations under the securities they have issued or guaranteed could cause a significant decline in the value or cash flow of our mortgage-backed securities. As of December 31, 2014, our investment portfolio also included $732.2 million, or 40.8% of our portfolio holdings, of obligations of state and other political subdivisions and $588.4 million, or 32.8% of our portfolio holdings, of corporate debt securities. We had gross unrealized losses of $9.8 million as of December 31, 2014, and $56.6 million as of December 31, 2013. Included in the gross unrealized losses as of December 31, 2014 and December 31, 2013 are $0.9 million and $8.1 million, respectively, related to noncurrent investments available-for-sale. We believe that these impairments are temporary and we do not intend to sell these investments. It is not likely that we will be required to sell any security in an unrealized loss position before recovery of its amortized cost basis. Given the current market conditions and the significant judgments involved, there is a continuing risk that further declines in fair value may occur and additional other-than-temporary impairments, which may be material, may be recorded in future periods. No impairment was recognized during the years ended December 31, 2014 or 2013.

Our total cash and cash equivalents as of December 31, 2014 and 2013 were $869.1 million and $433.2 million, respectively. The changes in cash and cash equivalents are summarized as follows:

	Year Ended December 31,		
	2014	2013	2012
	(Dollars in millions)		
Net cash provided by operating activities	$776.0	$95.8	$32.5
Net cash (used in) provided by investing activities	(184.9)	0.6	(12.6)
Net cash (used in) provided by financing activities	(155.2)	(3.4)	89.9
Net increase (decrease) in cash and cash equivalents	$435.9	$93.0	$109.8

Operating Cash Flows

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Net cash provided by operating activities increased by $680.2 million for the year ended December 31, 2014 compared to the same period in 2013. This increase was primarily due to the growth in our business related to the ACA and state exchange programs and Medicaid expansion, all which drove an increase in reserves for claims and other settlements.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Net cash provided by operating activities increased by $63.3 million for the year ended December 31, 2013 compared to the same period in 2012. This increase was primarily due to the timing of the payments received in 2013 from DHCS related to our California Medicaid business, including $150.9 million received for Medi-Cal rate changes. Our operating cash flow was also impacted by $47.9 million in premium tax payments made in 2013.

Investing Activities

Our cash flow from investing activities is primarily impacted by the sales, maturities and purchases of our available-for-sale investment securities and restricted investments. Our investment objective is to maintain safety and preservation of principal by investing in a diversified mix of high-quality, fixed-income securities, which are largely investment grade, while maintaining liquidity in each portfolio sufficient to meet our cash flow requirements and attaining an expected total return on invested funds.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Net cash used in investing activities increased by $185.5 million for the year ended December 31, 2014 compared to the year ended December 31, 2013. This increase was primarily due to a $192.4 million decrease in sales and maturities of available-for-sale investments, net of purchases.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Net cash provided by investing activities increased by $13.2 million for the year ended December 31, 2013 compared to the year ended December 31, 2012. This increase was primarily due to a $260.7 million decrease in net purchases of investments in available-for-sale securities during the year ended December 31, 2013, partially offset by $248.2 million in proceeds received for the sale of our Medicare PDP business during the year ended December 31, 2012.

Financing Activities

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Net cash used in financing activities increased by $151.8 million for the year ended December 31, 2014 as compared to the year ended December 31, 2013 primarily due to a $119.5 million decrease in cash from customer funds administered and a $74.7 million increase in share repurchases, partially offset by a $23.8 million increase in checks outstanding and a $17.0 million increase in proceeds from the exercise of stock options and employee stock purchases.

Customer funds administered include pass-through items and items accounted for under deposit accounting and are comprised of health care cost payments and reimbursements for the T-3 contract, catastrophic reinsurance subsidy, low-income member cost sharing subsidy and the coverage gap discount under the Medicare Part D program, and pass-through items related to our Medicaid program, including inter-governmental transfers, and the ACA premium stabilization program. See Note 2 to our consolidated financial statements for more information.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Net cash provided by financing activities decreased by $93.3 million for the year ended December 31, 2013 as compared to the year ended December 31, 2012 primarily due to a $47.7 million decrease in checks outstanding and a $38.1 million decrease in cash from customer funds administered.

Capital Structure

Our debt-to-total capital ratio was 22.6 percent as of December 31, 2014 compared with 23.5 percent as of December 31, 2013. This decrease is due to an increase in stockholders' equity primarily resulting from net income, an increase in additional paid-in capital due to stock option exercises, the vesting of certain equity awards and share-based compensation expense, and a decrease in accumulated other comprehensive loss, partially offset by an increase in treasury stock due to shares repurchased under the Company's stock repurchase program and shares withheld in connection with the exercise and vesting of equity awards.

Stock Repurchase Program

On May 2, 2011, our Board of Directors authorized our stock repurchase program pursuant to which a total of $300 million of our outstanding common stock could be repurchased. On March 8, 2012, our Board of Directors approved a $323.7 million increase to our stock repurchase program. During the year ended December 31, 2014, we repurchased 3.0 million shares of our common stock for aggregate consideration of $137.8 million under our stock repurchase program.

On December 16, 2014, our Board of Directors approved another increase to our stock repurchase program, which, when taken together with the remaining authorization at that time, brought our total authorization up to $400.0 million. As of December 31, 2014, the remaining authorization under our stock repurchase program was $400.0 million.

As of January 31, 2015, we had repurchased 1.1 million shares of our common stock for aggregate consideration of $57.7 million. We primarily funded these repurchases through our revolving credit facility. For additional information on our stock repurchase program, see "—Revolving Credit Facility" below and Note 9 to our consolidated financial statements.

Revolving Credit Facility

In October 2011, we entered into a $600 million unsecured revolving credit facility due in October 2016, which includes a $400 million sublimit for the issuance of standby letters of credit and a $50 million sublimit for swing line loans (which sublimits may be increased in connection with any increase in the credit facility described below). In addition, we have the ability from time to time to increase the credit facility by up to an additional $200 million in the aggregate, subject to the receipt of additional commitments. As of December 31, 2014, $100.0 million was outstanding under our revolving credit facility and the maximum amount available for borrowing under the revolving credit facility was $491.4 million (see "—Letters of Credit" below). As of February 23, 2015, we had $165 million in borrowings outstanding under our revolving credit facility. This increase in outstanding borrowings was primarily driven by draws on our revolving credit facility to fund repurchases of our common stock through our stock repurchase program.

Amounts outstanding under our revolving credit facility bear interest, at the Company's option, at either (a) the base rate (which is a rate per annum equal to the greatest of (i) the federal funds rate plus one-half of one percent, (ii) Bank of America, N.A.'s "prime rate" and (iii) the Eurodollar Rate (as such term is defined in the credit facility) for a one-month interest period plus one percent) plus an applicable margin ranging from 45 to 105 basis points or (b) the Eurodollar Rate plus an applicable margin ranging from 145 to 205 basis points. The applicable margins are based on our consolidated leverage ratio, as specified in the credit facility, and are subject to adjustment following the Company's delivery of a compliance certificate for each fiscal quarter.

Our revolving credit facility includes, among other customary terms and conditions, limitations (subject to specified exclusions) on our and our subsidiaries' ability to incur debt; create liens; engage in certain mergers, consolidations and acquisitions; sell or transfer assets; enter into agreements that restrict the ability to pay dividends or make or repay loans or advances; make investments, loans, and advances; engage in transactions with affiliates; and make dividends. In addition, we are required to be in compliance at the end of each fiscal quarter with a specified consolidated leverage ratio and consolidated fixed charge coverage ratio.

Our revolving credit facility contains customary events of default, including nonpayment of principal or other amounts when due; breach of covenants; inaccuracy of representations and warranties; cross-default and/or cross-acceleration to other indebtedness of the Company or our subsidiaries in excess of $50 million; certain ERISA-related events; noncompliance by the Company or any of our subsidiaries with any material term or provision of the HMO Regulations or Insurance Regulations (as each such term is defined in the credit facility) in a manner that could reasonably be expected to result in a material adverse effect; certain voluntary and involuntary bankruptcy events; inability to pay debts; undischarged, uninsured judgments greater than $50 million against us and/or our subsidiaries that are not stayed within 60 days; actual or asserted invalidity of any loan document; and a change of control. If an event of default occurs and is continuing under the revolving credit facility, the lenders thereunder may, among other things, terminate their obligations under the facility and require us to repay all amounts owed thereunder.

As of December 31, 2014, we were in compliance with all covenants under our revolving credit facility.

Letters of Credit

Pursuant to the terms of our revolving credit facility, we can obtain letters of credit in an aggregate amount of $400 million and the maximum amount available for borrowing is reduced by the dollar amount of any outstanding letters of credit. As of December 31, 2014 and February 23, 2015, we had outstanding letters of credit of $8.6 million and $6.7 million, respectively, resulting in a maximum amount available for borrowing of $491.4 million as of December 31, 2014 and $428.3 million as of February 23, 2015. As of December 31, 2014 and February 23, 2015, no amounts had been drawn on these letters of credit.

Senior Notes

We have issued $400 million in aggregate principal amount of 6.375% Senior Notes due 2017 (the “Senior Notes”). The indenture governing the Senior Notes limits our ability to incur certain liens, or consolidate, merge or sell all or substantially all of our assets. In the event of the occurrence of both (1) a change of control of Health Net, Inc. and (2) a below investment grade rating by any two of Fitch, Inc., Moody’s Investors Service, Inc. and Standard & Poor’s Ratings Services within a specified period, we will be required to make an offer to purchase the Senior Notes at a price equal to 101% of the principal amount of the Senior Notes plus accrued and unpaid interest to the date of repurchase. As of December 31, 2014, we were in compliance with all of the covenants under the indenture governing the Senior Notes.

The Senior Notes may be redeemed in whole at any time or in part from time to time, prior to maturity at our option, at a redemption price equal to the greater of:

- 100% of the principal amount of the Senior Notes then outstanding to be redeemed; or
- the sum of the present values of the remaining scheduled payments of principal and interest on the Senior Notes to be redeemed (not including any portion of such payments of interest accrued to the date of redemption) discounted to the date of redemption on a semiannual basis (assuming a 360-day year consisting of twelve 30-day months) at the applicable treasury rate plus 30 basis points

plus, in each case, accrued and unpaid interest on the principal amount being redeemed to the redemption date.

Each of the following will be an Event of Default under the indenture governing the Senior Notes:

- failure to pay interest for 30 days after the date payment is due and payable; provided that an extension of an interest payment period by us in accordance with the terms of the Senior Notes shall not constitute a failure to pay interest;
- failure to pay principal or premium, if any, on any note when due, either at maturity, upon any redemption, by declaration or otherwise;
- failure to perform any other covenant or agreement in the notes or indenture for a period of 60 days after notice that performance was required;
- (A) our failure or the failure of any of our subsidiaries to pay indebtedness for money we borrowed or any of our subsidiaries borrowed in an aggregate principal amount of at least $50 million, at the later of final maturity and the expiration of any related applicable grace period and such defaulted payment shall not have been made, waived or extended within 30 days after notice or (B) acceleration of the maturity of

indebtedness for money we borrowed or any of our subsidiaries borrowed in an aggregate principal amount of at least $50 million, if that acceleration results from a default under the instrument giving rise to or securing such indebtedness for money borrowed and such indebtedness has not been discharged in full or such acceleration has not been rescinded or annulled within 30 days after notice; or

- events in bankruptcy, insolvency or reorganization of our Company.

Statutory Capital Requirements

Certain of our subsidiaries must comply with minimum capital and surplus requirements under applicable state laws and regulations, and must have adequate reserves for claims. As necessary, we make contributions to and issue standby letters of credit on behalf of our subsidiaries to meet risk-based capital ("RBC") or other statutory capital requirements under state laws and regulations. We believe that as of February 23, 2015, all of our active health plans and insurance subsidiaries were in compliance with their respective regulatory requirements relating to maintenance of minimum capital standards, surplus requirements and adequate reserves for claims in all material respects.

By law, regulation and governmental policy, our health plan and insurance subsidiaries, which we refer to as our regulated subsidiaries, are required to maintain minimum levels of statutory capital and surplus. The minimum statutory capital and surplus requirements differ by state and are generally based on balances established by statute, a percentage of annualized premium revenue, a percentage of annualized health care costs, or RBC or tangible net equity ("TNE") requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners. The RBC formula, which calculates asset risk, underwriting risk, credit risk, business risk and other factors, generates the authorized control level ("ACL"), which represents the minimum amount of capital and surplus believed to be required to support the regulated entity's business. For states in which the RBC requirements have been adopted, the regulated entity typically must maintain the greater of the Company Action Level RBC, calculated as 200% of the ACL, or the minimum statutory capital and surplus requirement calculated pursuant to pre-RBC guidelines. Because our regulated subsidiaries are also subject to their state regulators' overall oversight authority, some of our subsidiaries are required to maintain minimum capital and surplus in excess of the RBC requirement, even though RBC has been adopted in their states of domicile.

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene"), certain of our California subsidiaries must comply with TNE requirements. Under these Knox-Keene TNE requirements, actual net worth less unsecured receivables and intangible assets must be more than the greater of (i) a fixed minimum amount, (ii) a minimum amount based on premiums or (iii) a minimum amount based on health care expenditures, excluding capitated amounts. In addition, certain of our California subsidiaries have made certain undertakings to the DMHC to restrict dividends and loans to affiliates, to the extent that the payment of such would reduce such entities' TNE below the minimum requirement or 130% of the minimum requirement. As of February 23, 2015, all of our subsidiaries subject to the TNE requirements and the undertakings to DMHC exceeded the minimum requirements.

Legislation may be enacted in certain states in which our 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 of our subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to their parent companies. Such restrictions, unless amended or waived or unless regulatory approval is granted, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends that can be paid by our insurance company subsidiaries without prior approval of the applicable state insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus.

Contractual Obligations

Our significant contractual obligations as of December 31, 2014 are summarized below for the years ending December 31:

	Total	2015	2016	2017	2018	2019	Thereafter	
	(Dollars in millions)							
Fixed-rate borrowing principal (c)	$ 400.0	$ —	$ —	$ 400.0	$ —	$ —	$ —	
Fixed-rate borrowing interest	61.7	25.5	25.5	10.7	—	—	—	
Variable-rate borrowing principal	100.0	—	100.0	—	—	—	—	
Variable-rate borrowing interest	3.8	1.8	2.0	—	—	—	—	
Operating leases	237.4	55.5	49.8	38.2	26.1	21.3	46.5	
Long-term purchase obligations	746.9	314.4	244.1	110.8	77.6	—	—	
Uncertain tax positions liability, including interest and penalties (b)	7.2	7.2	—	—	—	—	—	
Deferred compensation	50.6	4.1	3.6	3.3	2.3	2.0	35.3	(a)
Estimated future payments for pension and other benefits	41.6	2.6	3.9	3.9	3.9	3.9	23.4	(a)

____

(a) Represents estimated future payments from 2020 through 2024.

(b) The obligations shown above represent uncertain tax positions expected to be paid within the reporting periods presented. In addition to the obligations shown above, approximately $25.7 million of unrecognized tax benefits have been recorded as a liability, and we are uncertain as to if or when such amounts may be settled or paid.

(c) These amounts are based on stated terms and expected payments. As such, they differ from the amounts reported on our consolidated balance sheet and notes, which are reported consistently with the financial reporting and classification requirements.

Operating Leases

We lease office space under various operating leases. Certain leases are cancelable with substantial penalties. See "Item 2. Properties" for additional information regarding our leases.

Long-Term Purchase Obligations and Commitments

We have entered into long-term agreements to purchase various services, which may contain certain termination provisions and have remaining terms in excess of one year as of December 31, 2014.

We have entered into long-term agreements to receive services related to disease management, case management, wellness, pharmacy benefit management, pharmacy claims processing services and health quality/risk scoring enhancement services with external third-party service providers. The remaining terms are approximately from one to two years for each of these contracts. Termination of these agreements is subject to certain termination provisions. As of December 31, 2014, the total estimated future commitments under these agreements were $122.1 million and are included in the table above.

We have entered into an agreement with International Business Machines Corporation ("IBM") to outsource our IT infrastructure management services including data center services, IT security management and help desk support. In 2014, we extended the agreement and as of December 31, 2014, the remaining term of this contract was approximately one year, and total estimated future commitments under the agreement were approximately $101.2 million. We have entered into an agreement with Cognizant to outsource our software applications development and management activities to Cognizant. Under the terms of the agreement, Cognizant will, among other things, provide us with application development, testing and monitoring services, application maintenance and support services, project management services and cross functional services. In 2014, we extended the agreement, and as of December 31, 2014, the remaining term of this contract was approximately four years, and the total estimated future commitments under the agreement were approximately $288.1 million.

We have also entered into another agreement with Cognizant to outsource a substantial portion of our claims processing activities to Cognizant. Under the terms of the agreement, Cognizant will, among other things, provide us with claims adjudication, adjustment, audit and process improvement services. As of December 31, 2014, the remaining

term of this contract was approximately two years, and the total estimated future commitments under the agreement were approximately $25.4 million.

We have excluded from the table above amounts already recorded in our current liabilities on our consolidated balance sheet as of December 31, 2014. We have also excluded from the table above various contracts we have entered into with our health care providers, health care facilities, the federal government and other contracts that we have entered into for the purpose of providing health care services. We have excluded those contracts that allow for cancellation without significant penalty, obligations that are contingent upon achieving certain goals and contracts for goods and services that are fulfilled by vendors within a short time horizon and within the normal course of business.

The future contractual obligations in the contractual obligations table are estimated based on information currently available. The timing of and the actual payment amounts may differ based on actual events.

Off-Balance Sheet Arrangements

As of December 31, 2014, we had no off-balance sheet arrangements as defined under Regulation S-K Item 303(a)(4) and the instructions thereto. See Note 6 to our consolidated financial statements for a discussion of our letters of credit.

Critical Accounting Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ materially from those estimates. Principal areas requiring the use of estimates include revenue recognition, health care costs, including IBNR amounts, reserves for contingent liabilities, amounts receivable or payable under government contracts, goodwill and other intangible assets, recoverability of long-lived assets and investments, and income taxes. Furthermore, starting in 2014, our critical accounting estimates have been and will continue to be impacted as a result of the implementation of certain provisions of the ACA. Accordingly, we consider accounting policies on these areas to be critical in preparing our consolidated financial statements. A material change in any one of these amounts may have a material impact on our consolidated results of operations and financial condition. A more detailed description of the significant accounting policies that we use in preparing our financial statements is included in Note 2 to our consolidated financial statements, which are included elsewhere in this Annual Report on Form 10-K.

Health Plan Services

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

Approximately 59%, 50%, and 45% in 2014, 2013 and 2012, respectively, of our health plan services premium revenues were generated under Medicare, Medicaid/Medi-Cal and Dual Eligibles contracts, as applicable. These revenues are subject to audit and retroactive adjustment by the respective fiscal intermediaries. Laws and regulations governing these programs, including CMS' methodology with respect to risk adjustment data validation (“RADV”) audits, are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount.

Our Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient and physician treatment settings. We and the health care providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. We estimate risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS.

Under the ACA, commercial health plans with MLRs on fully insured products, as calculated as set forth in the ACA, that fall below certain targets are required to rebate ratable portions of their premiums annually. We estimate such rebates based on calculation methodology set forth in the ACA. In addition to the rebates for the commercial health plans under the ACA, there is also a medical loss ratio corridor for the DHCS adult Medicaid expansion members under the state Medicaid program in California. If our MLR for this population is below 85%, then we would have to pay DHCS a rebate. If the MLR is above 95%, then DHCS would have to pay us additional premium. Our Medicaid contract with the state of Arizona contains profit-sharing or profit ceiling provisions. If our Arizona Medicaid profits were in excess of the amount we are allowed to fully retain, we record an estimated profit corridor payable balance.

On a monthly basis, we estimate the amount of uncollectible receivables to reflect allowances for doubtful accounts. The allowances for doubtful accounts are estimated based on the creditworthiness of our customers, our historical collection rates and the age of our unpaid balances. During this process, we also assess the recoverability of the receivables, and an allowance is recorded based upon their net realizable value. Those receivables that are deemed to be uncollectible, such as receivables from bankrupt employer groups, are fully written off against their corresponding asset account, with a debit to the allowance to the extent such an allowance was previously recorded.

Reserves for claims and other settlements include reserves for claims (IBNR claims and received but unprocessed claims), and other liabilities including capitation payable, shared risk settlements, provider disputes, provider incentives and other reserves for our Western Region Operations reporting segment. Because reserves for claims include various actuarially developed estimates, our actual health care services expenses may be more or less than our previously developed estimates. As of December 31, 2014, 63% of reserves for claims and other settlements were attributed to claims reserves. See Note 15 to our consolidated financial statements for a reconciliation of changes in the reserve for claims and material prior period reserve development.

We calculate our best estimate of the amount of our IBNR reserves in accordance with GAAP and using standard actuarial developmental methodologies. This method also is known as the chain-ladder or completion factor method. The developmental method estimates reserves for claims based upon the historical lag between the month when services are rendered and the month claims are paid while taking into consideration, among other things, expected medical cost inflation, seasonal patterns, product mix, benefit plan changes and changes in membership. A key component of the developmental method is the completion factor, which is a measure of how complete the claims paid to date are relative to the estimate of the claims for services rendered for a given period. While the completion factors are reliable and robust for older service periods, they are more volatile and less reliable for more recent periods since a large portion of health care claims are not submitted to us until several months after services have been rendered. Accordingly, for the most recent months, the incurred claims are estimated from a trend analysis based on per member per month claims trends developed from the experience in preceding months. This method is applied consistently year-over-year while assumptions may be adjusted to reflect changes in medical cost inflation, seasonal patterns, product mix, benefit plan changes and changes in membership, among other things.

An extensive degree of actuarial judgment is used in this estimation process, considerable variability is inherent in such estimates, and the estimates are highly sensitive to changes in medical claims submission and payment patterns and medical cost trends. As such, the completion factors and the claims per member per month trend factor are the most significant factors used in estimating our reserves for claims. Since a large portion of the reserves for claims is attributed to the most recent months, the estimated reserves for claims are highly sensitive to these factors. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by these factors:

Completion Factor (a) Percentage-point Increase (Decrease) in Factor	**Western Region Operations Health Plan Services (Decrease) Increase in Reserves for Claims**
2%	$ (74.5) million
1%	$ (38.1) million
(1)%	$ 40.0 million
(2)%	$ 82.1 million

Medical Cost Trend (b) Percentage-point Increase (Decrease) in Factor	Western Region Operations Health Plan Services Increase (Decrease) in Reserves for Claims
2%	$ 30.9 million
1%	$ 15.4 million
(1)%	$ (15.4) million
(2)%	$ (30.9) million

____

(a) Impact due to change in completion factor for the most recent three months. Completion factors indicate how complete claims paid to date are in relation to the estimate of total claims for a given period. Therefore, an increase in completion factor percent results in a decrease in the remaining estimated reserves for claims.

(b) Impact due to change in annualized medical cost trend used to estimate the per member per month cost for the most recent three months.

Our IBNR best estimate also includes a provision for adverse deviation, which is an estimate for known environmental factors that are reasonably likely to affect the required level of IBNR reserves. This provision for adverse deviation is intended to capture the potential adverse development from known environmental factors such as our entry into new geographical markets, changes in our geographic or product mix, the introduction of new customer populations, variation in benefit utilization, disease outbreaks, changes in provider reimbursement, fluctuations in medical cost trend, variation in claim submission patterns and variation in claims processing speed and payment patterns, changes in technology that provide faster access to claims data or change the speed of adjudication and settlement of claims, variability in claim inventory levels, non-standard claim development, and/or exceptional situations that require judgmental adjustments in setting the reserves for claims.

We consistently apply our IBNR estimation methodology from period to period. Our IBNR best estimate is 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. As additional information becomes known to us, we adjust our assumptions accordingly to change our estimate of IBNR. Therefore, if moderately adverse conditions do not occur, evidenced by more complete claims information in the following period, then our prior period estimates will be revised downward, resulting in favorable development. However, any favorable prior period reserve development would increase current period net income only to the extent that the current period provision for adverse deviation is less than the benefit recognized from the prior period favorable development. If moderately adverse conditions occur and are more acute than we estimated, then our prior period estimates will be revised upward, resulting in unfavorable development, which would decrease current period net income.

For the year ended December 31, 2014, we had $14.6 million in net favorable reserve developments related to prior years. This reserve development for the year ended December 31, 2014 consisted of $36.6 million in unfavorable prior year development primarily due to the existence of moderately adverse conditions and a release of $51.2 million of the provision for adverse deviation held at December 31, 2013. We believe that the $36.6 million unfavorable development for the year ended December 31, 2014 was primarily due to unanticipated benefit utilization in our commercial business arising from dates of service in the fourth quarter of 2013 as a result of an uncertain environment related to the ACA. For the year ended December 31, 2013, we had $56.2 million in favorable reserve developments related to prior years. We believe this favorable development was primarily due to the absence of moderately adverse conditions. As part of our best estimate for IBNR, the provision for adverse deviation recorded as of December 31, 2014 and December 31, 2013 was $77.7 million and $53.4 million, respectively. The increase in the provision for adverse deviation from December 31, 2013 to December 31, 2014 was primarily driven by growth in our new products offered or programs administered under the ACA. The reserve developments related to prior years for the years ended December 31, 2014 and 2013, when considered together with the provision for adverse deviation recorded as of December 31, 2014 and 2013, respectively, did not have a material impact on our operating results or financial condition.

We assess the profitability of contracts for providing health care services when operating results or forecasts indicate probable future losses. Significant factors that can lead to a change in our profitability estimates include premium yield and health care cost trend assumptions, risk share terms and non-performance of a provider under a capitated agreement resulting in membership reverting to fee-for-service arrangements with other providers. Contracts are grouped in a manner consistent with the method of determining premium rates. Losses are determined by comparing anticipated premiums to estimates for 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 losses are determined and are classified as health plan services. As of December 31, 2014, and 2013 we held no premium deficiency reserves.

Accounting for Certain Provisions of the ACA

Starting in 2014, our critical accounting estimates have been and will continue to be impacted as a result of the implementation of certain provisions of the ACA, including three premium stabilization provisions ("3Rs"): permanent risk adjustment, temporary risk corridor and transitional reinsurance as described below. See Note 2, under the heading "Accounting for Certain Provisions of the ACA," to our consolidated financial statements for additional information.

Premium-based Fee on Health Insurers

The ACA mandated significant reforms to various aspects of the U.S. health insurance industry. Among other things, the ACA imposes an annual premium-based fee on health insurers (the "health insurance industry fee") for each calendar year beginning on or after January 1, 2014 which is not deductible for federal income tax purposes and in many state jurisdictions. The health insurance industry fee is levied based on a ratio of an insurer's net health insurance premiums written for the previous calendar year compared to the U.S. health insurance industry total. We are required to estimate a liability for our portion of the health insurance industry fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the calendar year that it is payable.

Public Health Insurance Exchanges

The ACA requires the establishment of state-based, state and federal partnership or federally facilitated health insurance exchanges ("exchanges") where individuals and small groups may purchase health insurance coverage under regulations established by U.S. Department of Health and Human Services ("HHS"). We currently participate in exchanges in Arizona and California. Effective January 1, 2014, the ACA includes permanent and temporary premium stabilization provisions for transitional reinsurance, permanent risk adjustment, and temporary risk corridors (collectively referred to as the "3Rs"), which are applicable to those insurers participating inside, and in some cases outside, of the exchanges.

Member Related Components

Member Premium—We receive a monthly premium from members. The member premium, which is fixed for the entire plan year, is recognized evenly over the contract period and reported as part of health plan services premium revenue.

Premium Subsidy—For qualifying low-income members, HHS will reimburse us, on the member’s behalf, some or all of the monthly member premium depending on the member’s income level in relation to the Federal Poverty Level. We recognize the premium subsidy evenly over the contract period and report it as part of health plan services premium revenue.

Cost Sharing Subsidy—For qualifying low-income members, HHS will reimburse us, on the member’s behalf, some or all of a member’s cost sharing amounts (e.g., deductible, co-pay/coinsurance). The amount paid for the member by HHS is dependent on the member’s income level in relation to the Federal Poverty Level. The Cost Sharing Subsidy offsets health care costs when incurred. We record a liability if the Cost Sharing Subsidy is paid in advance or a receivable if incurred health care costs exceed the Cost Sharing Subsidy received to date.

3Rs: Reinsurance, Risk Adjustment and Risk Corridor

Our accounting estimates are impacted as a result of the provisions of the ACA, including the 3Rs. The substantial influx of previously uninsured individuals into the new health insurance exchanges under the ACA could make it more difficult for health insurers, including us, to establish pricing accurately, at least during the early years of the exchanges. The 3Rs are intended to mitigate some of the risks around pricing and lack of information surrounding the previously uninsured. We will experience premium adjustments to our health plan services premium revenues and health plan services expenses based on changes to our estimated amounts related to the 3Rs. Such estimated amounts may differ materially from actual amounts ultimately received or paid under the provisions, which may have a material impact on our consolidated results of operations and financial condition.

Reinsurance-The transitional reinsurance program requires us to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans in the individual commercial market will be eligible for recoveries if individual claims exceed a specified threshold. Accordingly, we account for transitional reinsurance contributions associated with all commercial medical health plans other than non-grandfathered individual plans as an assessment in general and administrative expenses in our consolidated statement of income. We account for contributions made by individual commercial plans which are subject to recoveries as contra-health plan services premium revenue, and we account for any recoveries as contra-health plan services expense in our consolidated statements of income with a corresponding current or long-term receivable or payable.

Risk Adjustment-The risk adjustment provision applies to individual and small group business both within and outside the exchange and requires measurement of the relative health status risk of each insurer's pool of insured enrollees in a given market. The risk adjustment provision then operates to transfer funds from insurers whose pools of insured enrollees have a lower-than-average risk scores to those insurers whose pools have greater-than-average risk scores. Our estimate for the risk adjustment incorporates our risk scores by state and market relative to the market average using data provided by the participating insurers and available information about the HHS model. This information is consistent with our knowledge and understanding of market conditions.

As part of our ongoing estimation process, we consider information as it becomes available at interim dates along with our actuarially determined expectations, and we update our estimates incorporating such information as appropriate.

We estimate and recognize adjustments to our health plan services premium revenue for the risk adjustment provision by projecting our ultimate premium for the calendar year. Such estimated calendar year amounts are recognized ratably during the year and are revised each period to reflect current experience. We record receivables and/or payables and classify the amounts as current or long-term in the consolidated balance sheets based on the timing of expected settlement.

Risk Corridor-The temporary risk corridor program will be in place for three years and applies to individual and small group business operating both inside and outside of the exchanges. The risk corridor provisions limit health insurers' gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Variances from the target exceeding certain thresholds may result in HHS making additional payments to us or require us to make payments to HHS.

We estimate and recognize adjustments to our health plan services premium revenue for the risk corridor provision by projecting our ultimate premium for the calendar year. Such estimated calendar year amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk adjustment and reinsurance recoverables. We record receivables or payables and classify the amounts as current or long-term in the consolidated balance sheets based on the timing of expected settlement.

The final reconciliation and settlement with HHS of the premium and cost sharing subsidies and the amounts related to the 3Rs for the current year will be completed in the following year with HHS.

Government Contracts

On April 1, 2011, we began delivery of administrative services under our T-3 contract. For additional information on our T-3 contract, see "—Government Contracts Reportable Segment."

Under the T-3 contract for the TRICARE North Region, we provide various types of administrative services, including: provider network management, referral management, medical management, disease management, enrollment, customer service, clinical support service, and claims processing. We also provided assistance in the transition into the T-3 contract, and will provide assistance in any transition out of the T-3 contract. These services are structured as cost reimbursement arrangements for health care costs plus administrative fees earned in the form of fixed prices, fixed unit prices, and contingent fees and payments based on various incentives and penalties.

In accordance with GAAP, we evaluate, at the inception of the contract and as services are delivered, all deliverables in the service arrangement to determine whether they represent separate units of accounting. The delivered items are considered separate units of accounting if the delivered items have value to the customer on a standalone basis (i.e., they are sold separately by any vendor) and no general right of return exists relative to the delivered item. While we identified two separate units of accounting within the T-3 contract, no determination of estimated selling price was performed because both units of accounting are performed ratably over the option periods and, accordingly, the same methodology of revenue recognition applies to both units of accounting.

Therefore, we recognize revenue related to administrative services on a straight-line basis over the option period, when the fees become fixed and determinable.

The T-3 contract includes various performance-based incentives and penalties. For each of the incentives or penalties, we adjust revenue accordingly based on the amount that we have earned or incurred at each interim date and are legally entitled to in the event of a contract termination.

Revenues and expenses associated with the T-3 contract are reported as part of government contracts revenues and government contracts expenses, respectively, in the consolidated statements of operations and included in our Government Contracts reportable segment.

Amounts receivable under government contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract. Pursuant to our T-3 contract, the government has the right to unilaterally modify the contract in certain respects by issuing change orders directing us to implement terms or services that were not originally included in the contract. Following receipt of a change order, we have a contractual right to negotiate an equitable adjustment to the contract terms to account for the impact of the change order. We start to perform under such change orders and begin to incur associated costs after we receive the government's unilateral modification, but before we have negotiated the final scope and/or value of the change order. In these situations, costs are expensed as incurred, and we estimate and record revenue when we have met all applicable revenue recognition criteria. These criteria include the requirements that change order amounts are determinable, that we have performed under the change orders, and that collectability of amounts payable to us is reasonably assured.

Reserves For Contingent Liabilities

In the course of our operations, we are involved on a routine basis in various disputes with members, health care providers, and other entities or individuals, as well as audits or investigations by government agencies and elected officials that relate to our services and/or business practices that expose us to potential losses.

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

Goodwill and Other Intangible Assets

Goodwill and other intangible assets arise primarily as a result of various business acquisitions. Goodwill consists of the excess of the cost of acquisitions over the tangible and intangible assets acquired and liabilities assumed. Other intangible assets consist of identifiable intangible assets acquired and the value of provider networks and customer relationships, which are all subject to amortization.

On November 2, 2014, we signed a definitive master services agreement with Cognizant to provide certain services to us. In connection with this agreement, we have agreed to sell certain software assets and related intellectual property ("software system assets") we own to Cognizant. The transaction, including the related asset sale, is subject to the receipt of required regulatory approvals. See "—Cognizant Transaction" and Note 3 to our consolidated financial statements for additional information regarding our agreements with Cognizant. Because the sale of these software system assets meets the definition of a sale of a business under GAAP, as of September 30, 2014, we re-allocated $7 million of goodwill based on relative fair values of the Western Region Operations reporting unit with and without the impact of the business to be sold. Our measurement of fair values is based on a combination of the discounted total consideration expected to be received in connection with the services and asset sale agreements, income approach based on a discounted cash flow methodology, and replacement cost methodology. After the reallocation of goodwill, we performed a two-step impairment test to determine the existence of any impairment and the amount of the impairment. In the first step, we compared the fair values to the related carrying value and concluded that the carrying value of the business to be sold was impaired; however, we determined that the carrying value of the Western Region Operations reporting unit was not impaired. In the second step, we measured the impairment amount by comparing the implied value of the allocated goodwill to the carrying amount of such goodwill. Based on the results of our Step 2 test, we concluded that the implied value of the goodwill allocated to the business to be sold was zero, which resulted in an impairment charge for the total carrying value of the allocated goodwill of $7 million. See Note 7 to our consolidated financial statements for additional goodwill fair value measurement information.

We perform our annual impairment test on our recorded goodwill as of June 30 or more frequently if events or changes in circumstances indicate that we might not recover the carrying value of these assets for each of our reporting units. We performed our annual impairment test on our goodwill and other intangible assets as of June 30, 2014 for our Western Region Operations reporting unit, and no impairment was identified. We performed a two-step impairment test to determine the existence of impairment and the amount of the impairment. In the first step, we compared the fair values to the related carrying values and concluded that the carrying value of the Western Region Operations was not impaired. As a result, the second step was not performed. We also re-evaluated the useful lives of our other intangible assets and determined that the current estimated useful lives were properly reflected.

Due to the many variables inherent in the estimation of a business's fair value and the relative size of recorded goodwill, changes in assumptions may have a material effect on the results of our impairment test. The discounted cash flows and market participant valuations (and the resulting fair value estimates of the Western Region Operations reporting unit) are sensitive to changes in assumptions including, among others, certain valuation and market assumptions. Changes to any of these assumptions could cause the fair value of our Western Region Operations reporting unit to be below its carrying value. The ratio of the fair value of our Western Region Operations reporting unit to its carrying value was approximately 224% and 149% as of September 30, 2014 and June 30, 2013, respectively.

Recoverability of Long-Lived Assets and Investments

We periodically assess the recoverability of our long-lived assets including property and equipment and other long-term assets and investments where events and changes in circumstances would indicate that we might not recover the carrying value as follows:

Long-lived Assets Held and Used

We test long-lived assets or asset groups for recoverability when events or changes in circumstances indicate that their carrying amount may not be recoverable. Circumstances which could trigger a review include, but are not limited to: significant decreases in the market price of the asset, significant adverse changes in the business climate or legal factors, current period cash flow or operating losses combined with a history of losses or a forecast of continuing losses associated with the use of the asset and current expectation that the asset will more likely than not be sold or disposed of significantly before the end of its estimated useful life.

If we identify an indicator of impairment, we assess recoverability by comparing the carrying amount of the asset to the sum of the undiscounted cash flows expected to result from the use and the eventual disposal of the asset. An impairment loss is recognized when the carrying amount is not recoverable and is measured as the excess of carrying value over fair value.

In connection with the Cognizant Transaction, we classified certain software systems assets as held-for-sale. As of December 31, 2014, we had classified software systems assets with a total net book value of $130.2 million as assets held for sale. We assessed the recoverability of these assets held for sale and as a result, we recorded $80.2 million in asset impairments during the year ended December 31, 2014. See Note 3 for more information regarding assets held for sale and the Cognizant Transaction. In addition, we recorded an asset impairment of $1.3 million during the year ended December 31, 2014 for internally developed software.

Income Taxes

We record 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. We establish a valuation allowance in accordance with the provisions of the Income Taxes Topic of the Financial Accounting Standards Board ("FASB") codification. We continually review the adequacy of the valuation allowance and recognize the benefits from our deferred tax assets only when an analysis of both positive and negative factors indicate that it is more likely than not that the benefits will be realized.

We file tax returns in many tax jurisdictions. Often, application of tax rules within the various jurisdictions is subject to differing interpretation. Despite our belief that our tax return positions are fully supportable, we believe that it is probable certain positions will be challenged by taxing authorities, and we may not prevail on all of the positions as filed. Accordingly, we maintain a liability for the estimated amount of contingent tax challenges by taxing authorities upon examination. We analyze the amount at which each tax position meets a "more likely than not" standard for sustainability upon examination by taxing authorities. Only tax benefit amounts meeting or exceeding this standard will be reflected in tax provision expense and deferred tax asset balances. Any difference between the amounts of tax benefits reported on tax returns and tax benefits reported in the financial statements is recorded as a liability for unrecognized tax benefits. The liability for unrecognized tax benefits is reported separately from deferred tax assets and liabilities and classified as current or noncurrent based upon the expected period of payment.

In 2015, due to the non-deductibility of the health insurer fee for federal income tax purposes, we expect our full-year effective income tax rate will exceed 50%. See "Overview—Health Care Reform Legislation and Implementation" and "—Results of Operations—Income Tax Provision" above.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are exposed to interest rate and market risk primarily due to our 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/or market conditions and in equity prices. Interest rate risk is a consequence of maintaining variable interest rate earning investments and fixed rate liabilities or fixed income investments and variable rate liabilities. We are 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, we are exposed to the risk of loss related to changes in credit spreads. Credit spread risk arises from the potential changes in an issuer's credit rating or credit perception that may affect the value of financial instruments.

We attempt to manage the interest rate risks related to our investment portfolios by actively managing the asset duration of our investment portfolios. The overall goal for the investment portfolios is to provide a source of liquidity and support the ongoing operations of our business units. Our 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. We manage these risks by setting risk tolerances, targeting asset-class allocations, diversifying among assets and asset characteristics, and using performance measurement and reporting.

We use a value-at-risk ("VAR") model, which follows a variance/co-variance methodology, to assess the market risk for our 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.

We assumed a portfolio disposition period of 30 days with a confidence level of 95% for the computation of VAR for 2014. The computation further assumes that the distribution of returns is normal. Based on such methodology and assumptions, the computed VAR was approximately $9.3 million as of December 31, 2014.

Our calculated VAR exposure represents an estimate of reasonably possible net losses that could be recognized on our 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 our investment portfolios during the year.

Except for those securities held by trustees or regulatory agencies (see Note 2 to our consolidated financial statements), all of our investment securities are designated as "available-for-sale" assets. As such, they are reflected at their estimated fair value, with the difference between cost and estimated fair value reflected in accumulated other comprehensive income, net of tax, a component of Stockholders' Equity (see Note 4 to our consolidated financial statements). All of our investment securities are fixed income securities. Approximately 24% of our available-for-sale investment securities are asset-backed securities ("ABS")/mortgage-backed securities ("MBS"). Approximately 50% of the ABS/MBS are agency securities. Therefore, we believe that our exposure to credit-related market value risk for our MBS is limited. Generally, in a rising interest rate environment, the estimated fair value of fixed income securities would be expected to decrease; conversely, in a decreasing interest rate environment, the estimated fair value of fixed income securities would be expected to increase. However, these securities may be negatively impacted by illiquidity in the market. The recent disruptions in the credit markets have negatively impacted the liquidity of investments. However, such disruptions did not have a material impact to the liquidity of our investments. A worsening of credit market function or sustained market downturns could have negative effects on the liquidity and value of our investment assets.

Borrowings under our revolving credit facility, which totaled $100.0 million as of December 31, 2014, are subject to variable interest rates. For additional information regarding our revolving credit facility, see "—Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources." Our floating rate borrowings, if any, are presumed to have equal book and fair values because the interest rates paid on these borrowings, if any, are based on prevailing market rates.

The fair value of our fixed rate borrowing, which consists of only our Senior Notes, as of December 31, 2014 was approximately $437.0 million, which was based on quoted market prices. Where quoted market prices were not readily available, fair values were estimated using valuation methodologies based on available and observable market information. Such valuation methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly traded companies in a similar line of business, and reviewing the underlying financial performance including estimating discounted cash flows. The following table presents the expected cash outflows relating to market risk sensitive debt obligations as of December 31, 2014. These cash outflows include expected principal and interest payments consistent with the terms of the outstanding debt as of December 31, 2014.

	2015	2016	2017	2018	2019	Thereafter	Total
	(Amounts in millions)						
Fixed-rate borrowing:							
Principal	$ —	$ —	$ 400.0	$ —	$ —	$ —	$ 400.0
Interest	25.5	25.5	10.7	—	—	—	61.7
Cash outflow on fixed-rate borrowing	$ 25.5	$ 25.5	$ 410.7	$ —	$ —	$ —	$ 461.7
Variable-rate borrowing:							
Principal	$ —	$ 100.0	$ —	$ —	$ —	$ —	$ 100.0
Interest	1.8	2.0	—	—	—	—	3.8
Cash outflow on variable-rate borrowing	$ 1.8	$ 102.0	$ —	$ —	$ —	$ —	$ 103.8
Total cash outflow on borrowings	$ 27.3	$ 127.5	$ 410.7	$ —	$ —	$ —	$ 565.5

Item 8. Financial Statements and Supplementary Data.

The financial statements listed on the accompanying Index to Consolidated Financial Statements set forth on page F-1 and covered by the Report of Independent Registered Public Accounting Firm are incorporated in this Item 8 by reference and filed as part of this Annual Report on Form 10-K.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure.

Not applicable.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

We maintain disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) that are designed to ensure that information required to be disclosed in the reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and our Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognized that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management necessarily was required to apply its judgment in evaluating the cost-benefit relationship of possible controls and procedures.

As required by Rule 13a-15(b) under the Exchange Act, we carried out an evaluation, under the supervision and with the participation of our management, including our Chief Executive Officer and our Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report. Based upon the evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of the end of such period.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. Our management, under the supervision and with the participation of our principal executive officer and principal financial officer, conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control—Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on its evaluation, management concluded that our internal control over financial reporting was effective as of December 31, 2014.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Projections of any evaluation of effectiveness to future periods are subject to the risks that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Deloitte & Touche, LLP, the independent registered public accounting firm that audited the financial statements included in this Annual Report on Form 10-K, has issued an attestation report on our internal control over financial reporting as of December 31, 2014, which is included herein.

Changes in Internal Control Over Financial Reporting

There have not been any changes in the Company's internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) during the fourth quarter ended December 31, 2014 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have audited the internal control over financial reporting of Health Net, Inc. and subsidiaries (the "Company") as of December 31, 2014, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management’s Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with accounting principles generally accepted in the United States of. America (“generally accepted accounting principles”). A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2014, of the Company, and our report dated February 27, 2015, expressed an unqualified opinion on those financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE, LLP

Los Angeles, California
February 27, 2015

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers of the Registrant and Corporate Governance.

The information required by this Item as to (1) directors and executive officers of the Company and (2) compliance with Section 16(a) of the Securities Exchange Act of 1934 is set forth in the Company’s definitive proxy statement for its 2015 Annual Meeting of Stockholders (the "Proxy Statement"), which will be filed with the SEC within 120 days of December 31, 2014. Such information is incorporated herein by reference and made a part hereof. We have adopted a Code of Business Conduct and Ethics that applies to our employees, directors and officers, including our principal executive officer, principal financial officer and principal accounting officer. The Code of Business Conduct and Ethics is posted on our Internet web site, *www.healthnet.com.* We intend to post on our Internet web site any amendment to or waiver from the Code of Business Conduct and Ethics that applies to our principal executive officer, principal financial officer or principal accounting officer and that is required to be disclosed under applicable rules and regulations of the SEC.

Item 11. Executive Compensation.

The information required by this Item is set forth in the Proxy Statement, which will be filed with the SEC within 120 days of December 31, 2014. Such information is incorporated herein by reference and made a part hereof.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The information required by this Item is set forth in the Proxy Statement, which will be filed with the SEC within 120 days of December 31, 2014. Such information is incorporated herein by reference and made a part hereof.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The information required by this Item is set forth in the Proxy Statement, which will be filed with the SEC within 120 days of December 31, 2014. Such information is incorporated herein by reference and made a part hereof.

Item 14. Principal Accountant Fees and Services.

The information required by this Item is set forth in the Proxy Statement, which will be filed with the SEC within 120 days of December 31, 2014. Such information is incorporated herein by reference and made a part hereof.

PART IV

Item 15. Exhibits and Financial Statement Schedule.

(a) Financial Statements, Schedule and Exhibits

1. Financial Statements

The financial statements listed on the accompanying Index to Consolidated Financial Statements set forth on page F-1 and covered by the Report of Independent Registered Public Accounting Firm are incorporated into this Item 15(a) by reference and filed as part of this Annual Report on Form 10-K.

2. Financial Statement Schedule

The financial statement schedule listed on the accompanying Index to Consolidated Financial Statements set forth on page F-1 and covered by the Report of Independent Registered Public Accounting Firm are incorporated into this Item 15(a) by reference and filed as part of this Annual Report on Form 10-K.

3. Exhibits

The exhibits listed in the Exhibit Index, which appears immediately following the Consolidated Financial Statements Schedule and is incorporated herein by reference, are filed as part of this Annual Report on Form 10-K.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

HEALTH NET, INC.

By: /S/ JAMES E. WOYS

James E. Woys

Chief Financial and Operating Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/S/ JAY M. GELLERT **Jay M. Gellert**	President and Chief Executive Officer and Director (Principal Executive Officer)	February 27, 2015
/S/ JAMES E. WOYS **James E. Woys**	Executive Vice President, Chief Financial and Operating Officer and Interim Treasurer (Principal Financial Officer)	February 27, 2015
/S/ MARIE MONTGOMERY **Marie Montgomery**	Senior Vice President and Corporate Controller (Principal Accounting Officer)	February 27, 2015
/s/ MARY ANNE CITRINO **Mary Anne Citrino**	Director	February 27, 2015
/s/ THEODORE F. CRAVER, JR. **Theodore F. Craver, Jr.**	Director	February 27, 2015
/S/ VICKI B. ESCARRA **Vicki B. Escarra**	Director	February 27, 2015
/S/ GALE S. FITZGERALD **Gale S. Fitzgerald**	Director	February 27, 2015
/S/ PATRICK FOLEY **Patrick Foley**	Director	February 27, 2015
/S/ ROGER F. GREAVES **Roger F. Greaves**	Director	February 27, 2015
/S/ DOUGLAS M. MANCINO **Douglas M. Mancino**	Director	February 27, 2015
/S/ BRUCE G. WILLISON **Bruce G. Willison**	Director	February 27, 2015
/s/ FREDERICK C. YEAGER **Frederick C. Yeager**	Director	February 27, 2015

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

The following consolidated financial statements and financial statement schedule are filed as part of this Annual Report on Form 10-K:

Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm	F-2
Consolidated Statements of Operations for each of the three years in the period ended December 31, 2014	F-3
Consolidated Statements of Comprehensive Income for each of the three years in the period ended December 31, 2014	F-4
Consolidated Balance Sheets as of December 31, 2014 and 2013	F-5
Consolidated Statements of Stockholders' Equity for each of the three years in the period ended December 31, 2014	F-6
Consolidated Statements of Cash Flows for each of the three years in the period ended December 31, 2014	F-7
Notes to Consolidated Financial Statements	F-8
Financial Statement Schedule	
Schedule I—Condensed Financial Information of Registrant (Parent Company Only)	F-63

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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, 2014 and 2013, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2014. Our audits also included the consolidated financial statement schedule listed in the index at page F-1. These consolidated financial statements and consolidated financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on the consolidated financial statements and consolidated financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall consolidated 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 the Company as of December 31, 2014 and 2013, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2014, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2014, based on the criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 27, 2015 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Los Angeles, California
February 27, 2015

HEALTH NET, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS
(Amounts in thousands, except per share data)

	Year Ended December 31,		
	2014	**2013**	**2012**
Revenues			
Health plan services premiums	$ 13,361,170	$ 10,377,073	$ 10,459,098
Government contracts	603,975	572,266	689,121
Net investment income	45,166	69,613	82,434
Administrative services fees and other income	(1,725)	34,791	17,968
Divested operations and services revenue	—	—	40,471
Total revenues	14,008,586	11,053,743	11,289,092
Expenses			
Health plan services (excluding depreciation and amortization)	11,307,751	8,886,547	9,316,313
Government contracts	536,643	502,918	605,074
General and administrative	1,552,364	1,083,694	939,940
Selling	262,338	239,428	245,925
Depreciation and amortization	29,786	38,589	31,146
Interest	31,376	32,614	33,220
Divested operations and services expenses	—	—	85,824
Asset impairment	88,536	—	—
Total expenses	13,808,794	10,783,790	11,257,442
Income from continuing operations before income taxes	199,792	269,953	31,650
Income tax provision	54,163	99,827	5,969
Income from continuing operations	145,629	170,126	25,681
Discontinued operations:			
(Loss) income from discontinued operation, net of tax	—	—	(18,452)
Gain on sale of discontinued operation, net of tax	—	—	114,834
Income from discontinued operation, net of tax	—	—	96,382
Net income	$ 145,629	$ 170,126	$ 122,063
Net income per share—basic:			
Income from continuing operations	$ 1.83	$ 2.14	$ 0.31
Income from discontinued operation, net of tax	$ —	$ —	$ 1.18
Net income per share—basic	$ 1.83	$ 2.14	$ 1.49
Net income per share—diluted:			
Income from continuing operations	$ 1.80	$ 2.12	$ 0.31
Income from discontinued operation, net of tax	$ —	$ —	$ 1.16
Net income per share—diluted	$ 1.80	$ 2.12	$ 1.47
Weighted average shares outstanding:			
Basic	79,602	79,455	82,158
Diluted	80,777	80,404	83,112

CDIx486

See accompanying notes to consolidated financial statements.

HEALTH NET, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(Amounts in thousands)

	Year Ended December 31,		
	2014	2013	2012
Net income	$ 145,629	$ 170,126	$ 122,063
Other comprehensive income before tax:			
Unrealized gains (losses) on investments available-for-sale:			
Unrealized holding gains (losses) arising during the period	59,073	(78,217)	65,462
Less: Reclassification adjustments for gains included in earnings	(2,710)	(23,975)	(36,680)
Unrealized gains (losses) on investments available-for-sale, net	56,363	(102,192)	28,782
Defined benefit pension plans:			
Prior service cost arising during the period	—	607	—
Net (loss) gain arising during the period	(11,893)	7,294	(646)
Less: Amortization of prior service cost and net loss included in net periodic pension cost	600	2,572	4,152
Defined benefit pension plans, net	(11,293)	10,473	3,506
Other comprehensive income (loss), before tax	45,070	(91,719)	32,288
Income tax expense (benefit) related to components of other comprehensive income	15,464	(31,868)	21,936
Other comprehensive income (loss), net of tax	29,606	(59,851)	10,352
Comprehensive income	$ 175,235	$ 110,275	$ 132,415

See accompanying notes to consolidated financial statements.

HEALTH NET, INC.

CONSOLIDATED BALANCE SHEETS
(Amounts in thousands, except per share data)

	December 31, 2014	December 31, 2013
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 869,133	$ 433,155
Investments-available-for-sale (amortized cost: 2014-$1,777,404, 2013-$1,602,456)	1,791,060	1,567,020
Premiums receivable, net of allowance for doubtful accounts (2014-$1,671, 2013-$643)	951,935	430,012
Amounts receivable under government contracts	150,546	194,041
Other receivables	424,910	68,919
Deferred taxes	57,911	94,060
Assets held for sale	50,000	—
Other assets	220,122	132,683
Total current assets	4,515,617	2,919,890
Property and equipment, net	84,328	201,395
Goodwill	558,886	565,886
Other intangible assets, net	11,822	13,842
Deferred taxes	33,081	5,793
Investments-available-for-sale-noncurrent (amortized cost: 2014-$5,474, 2013-$67,943)	4,570	59,768
Other noncurrent assets	187,630	162,551
Total Assets	$ 5,395,934	$ 3,929,125
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Reserves for claims and other settlements	$ 1,896,035	$ 984,075
Health care and other costs payable under government contracts	71,988	72,098
Unearned premiums	96,106	123,969
Accounts payable and other liabilities	880,374	397,036
Total current liabilities	2,944,503	1,577,178
Senior notes payable	399,504	399,300
Borrowings under revolving credit facility	100,000	100,000
Deferred taxes	—	10,409
Other noncurrent liabilities	242,705	213,427
Total Liabilities	3,686,712	2,300,314
Commitments and contingencies		
Stockholders' Equity:		
Preferred stock ($0.001 par value, 10,000 shares authorized, none issued and outstanding)	—	—

Common stock ($0.001 par value, 350,000 shares authorized; issued 2014-152,451 shares; 2013-150,224 shares)	153	150
Additional paid-in capital	1,444,705	1,377,624
Treasury common stock, at cost (2014-74,378 shares of common stock; 2013-70,704 shares of common stock)	(2,341,652)	(2,179,744)
Retained earnings	2,609,277	2,463,648
Accumulated other comprehensive (loss) income	(3,261)	(32,867)
Total Stockholders’ Equity	1,709,222	1,628,811
Total Liabilities and Stockholders’ Equity	$ 5,395,934	$ 3,929,125

See accompanying notes to consolidated financial statements.

HEALTH NET, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Amounts in thousands)

	Common Stock		Additional Paid-In	Common Stock Held in Treasury		Retained	Accumulated Other Comprehensive	
	Shares	Amount	Capital	Shares	Amount	Earnings	Income (Loss)	Total
Balance as of January 1, 2012	146,804	$ 147	$1,278,037	(64,847)	$(2,023,129)	$2,171,459	$ 16,632	$1,443,146
Net income						122,063		122,063
Other comprehensive income							10,352	10,352
Exercise of stock options and vesting of restricted stock units	1,923	2	16,940					16,942
Share-based compensation expense			28,893					28,893
Tax benefit related to equity compensation plans			5,130					5,130
Repurchases of common stock				(2,579)	(69,496)			(69,496)
Balance as of January 1, 2013	148,727	$ 149	$1,329,000	(67,426)	$(2,092,625)	$2,293,522	$ 26,984	$1,557,030
Net income						170,126		170,126
Other comprehensive loss							(59,851)	(59,851)
Exercise of stock options and vesting of restricted stock units	1,497	1	20,070					20,071
Share-based compensation expense			29,930					29,930
Tax detriment related to equity compensation plans			(1,376)					(1,376)
Repurchases of common stock				(3,278)	(87,119)			(87,119)
Balance as of January 1, 2014	150,224	$ 150	$1,377,624	(70,704)	$(2,179,744)	$2,463,648	$ (32,867)	$1,628,811
Net income						145,629		145,629
Other comprehensive income							29,606	29,606
Exercise of stock options and vesting of restricted stock units	2,227	3	37,651					37,654
Share-based compensation expense			28,334					28,334
Tax benefit related to equity compensation plans			1,096					1,096
Repurchases of common stock				(3,674)	(161,908)			(161,908)
Balance as of December 31, 2014	152,451	$ 153	$1,444,705	(74,378)	$(2,341,652)	$2,609,277	$ (3,261)	$1,709,222

See accompanying notes to consolidated financial statements.

HEALTH NET, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(Amounts in thousands)

	Year Ended December 31,		
	2014	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income	$ 145,629	$ 170,126	$ 122,063
Adjustments to reconcile net income to net cash provided by operating activities:			
Amortization and depreciation	29,786	38,589	31,146
Asset impairment charges	88,536	—	—
Gain on sale of discontinued operation	—	—	(114,834)
Share-based compensation expense	28,334	29,930	28,893
Deferred income taxes	(16,564)	8,645	8,924
Excess tax benefit on share-based compensation	(2,230)	(620)	(6,089)
Net realized gain on investments	(2,710)	(24,061)	(36,680)
Other changes	29,838	31,539	15,158
Changes in assets and liabilities, net of effects of acquisitions and dispositions:			
Premiums receivable and unearned premiums	(549,786)	(83,822)	(212,998)
Other current assets, receivables and noncurrent assets	(444,288)	1,425	(28,374)
Amounts receivable/payable under government contracts	39,754	20,896	(8,989)
Reserves for claims and other settlements	911,960	(53,898)	164,306
Accounts payable and other liabilities	517,742	(42,910)	70,014
Net cash provided by operating activities	776,001	95,839	32,540
CASH FLOWS FROM INVESTING ACTIVITIES:			
Sales of investments	441,430	696,534	1,350,003
Maturities of investments	98,901	93,225	135,394
Purchases of investments	(665,200)	(722,223)	(1,678,582)
Sales of property and equipment	—	—	24
Purchases of property and equipment	(62,010)	(59,525)	(73,101)
Net cash received from sale of business	—	—	248,238
Sales (purchases) of restricted investments and other	2,027	(7,432)	5,466
Net cash (used in) provided by investing activities	(184,852)	579	(12,558)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from exercise of stock options and employee stock purchases	27,727	10,762	16,941
Excess tax benefit on share-based compensation	2,230	620	6,089
Repurchases of common stock	(152,549)	(77,810)	(69,496)
Borrowings under financing arrangements	—	345,000	110,000
Repayment of borrowings under financing arrangements	—	(345,000)	(122,500)
Net (decrease) increase in checks outstanding, net of deposits	—	(23,842)	23,842
Customer funds administered	(32,579)	86,897	124,999
Net cash (used in) provided by financing activities	(155,171)	(3,373)	89,875
Net increase (decrease) in cash and cash equivalents	435,978	93,045	109,857
Cash and cash equivalents, beginning of year	433,155	340,110	230,253
Cash and cash equivalents, end of year	$ 869,133	$ 433,155	$ 340,110
SUPPLEMENTAL CASH FLOWS DISCLOSURE:			
Interest paid	$ 29,670	$ 30,789	$ 31,134
Income taxes paid	83,499	80,119	5,001
SUPPLEMENTAL SCHEDULE OF NON-CASH INVESTING AND FINANCING ACTIVITIES:			
Accretion of deferred revenues into earnings	—	—	12,000

See accompanying notes to consolidated financial statements.

HEALTH NET, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 1—Description of Business

Health Net, Inc. (referred to herein as "Health Net," "the Company," "we," "us," "our" or "HNT") is a publicly traded managed care organization that delivers managed health care services. Together with our subsidiaries, we provide health benefits through our health maintenance organizations ("HMOs"), insured preferred provider organizations ("PPOs"), exclusive provider organization ("EPO"), point of service ("POS") plans and indemnity products, among others, to approximately 6.0 million individuals across the country through group, individual, Medicare, Medicaid ("Medi-Cal" in California), the United States Department of Defense ("Department of Defense" or "DoD"), including TRICARE, and Veterans Affairs programs. Our subsidiaries also offer managed health care products related to behavioral health and prescription drugs. Starting in 2014, we participate in the California Coordinated Care Initiative ("CCI") and provide health care services to individuals that are fully eligible for Medicare and Medi-Cal benefits ("dual eligibles").

Our reportable segments are comprised of Western Region Operations and Government Contracts, each of which is described below. On November 2, 2014, we signed a definitive master services agreement with Cognizant Healthcare Services, LLC, a wholly owned subsidiary of Cognizant Technology Solutions Corporation ("Cognizant") to provide certain services to us. In connection with this agreement, we have also entered into an asset purchase agreement pursuant to which we have agreed to sell certain software assets and related intellectual property we own to Cognizant. The transaction, including the related asset sale (the "Cognizant Transaction"), is subject to receipt of required regulatory approvals. See Note 2 and Note 3 for more information on the Cognizant Transaction.

In connection with this Cognizant Transaction, we reviewed our reportable segments and determined that there were no changes to our reportable segments. Effective January 1, 2013, we closed out our Divested Operations and Services segment, which is described below. As a result of entering into a definitive agreement in January 2012 to sell our Medicare stand-alone Prescription Drug Plan ("Medicare PDP") business, we reviewed our reportable segments in the first quarter of 2012. Following this review, all services provided in connection with divested businesses, including those relating to the sale of our Medicare PDP business and the Northeast Sale (as defined below), were reported as part of our Divested Operations and Services reportable segment beginning in the first quarter of 2012. See Note 14 for a discussion of our reportable segments.

Our health plan services are provided under our Western Region Operations reportable segment, which includes the operations primarily conducted in California, Arizona, Oregon and Washington for our commercial, Medicare and Medicaid health plans, our health and life insurance companies, our pharmaceutical services subsidiary and certain operations of our behavioral health subsidiaries.

Our Government Contracts reportable segment includes our government-sponsored managed care federal contract with the DoD under the TRICARE program in the North Region and other health care, mental health and behavioral health government contracts. On April 1, 2011, we began delivering administrative services under the new T-3 contract for the TRICARE North Region ("T-3 contract"). The T-3 contract for the North Region covers Connecticut, Delaware, Illinois, Indiana, Kentucky (except Fort Campbell), Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin and the District of Columbia and portions of Iowa and Missouri. The Company provides administrative services to approximately 2.8 million Military Health System ("MHS") eligible individuals under the T-3 contract. In addition to the beneficiaries that we service under the T-3 contract, we administer contracts with the U.S. Department of Veterans Affairs ("VA") to manage community based outpatient clinics in one state covering approximately 3,696 enrollees and provide behavioral health services to military families under the Department of Defense sponsored Military and Family Life Counseling, formerly Military and Family Life Consultant, ("MFLC") program. Our Government Contracts segment also includes the services we provide under the Patient Centered Community Care program (“PC3 Program”) contract we have with the Department of Veterans Affairs (“VA”). See Note 2 under the heading "Government Contracts" for additional information on our T-3 contract for the North Region, the MFLC contract and PC3 Program contract.

On April 1, 2012, we completed the sale of the business operations of our Medicare PDP business to Pennsylvania Life Insurance Company, a subsidiary of CVS Caremark Corporation ("CVS Caremark"). Prior to the sale of our Medicare PDP business, our Divested Operations and Services reportable segment included the operations of our businesses that provided administrative and run-out support services to an affiliate of UnitedHealth Group Incorporated ("United") and its affiliates under administrative services and claims servicing agreements in connection with the sale of all of the outstanding shares of capital stock of our health plan subsidiaries that were domiciled and had conducted businesses in Connecticut, New Jersey, New York and Bermuda to United (the "Northeast Sale"). Beginning in the first quarter of 2012, this segment also included the transition-related expenses of our divested Medicare PDP business. As of December 31, 2012, we had substantially completed the administration and run-out of our divested businesses. See Note 2 for additional information on our Divested Operations and Services and Note 3 for more information on the Cognizant Transaction, the sale of our Medicare PDP business and the Northeast Sale.

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 subsidiaries. All intercompany transactions have been eliminated in consolidation.

On November 2, 2014, we signed a definitive master services agreement with Cognizant to provide certain services to us. In connection with this agreement, we have also entered into an asset purchase agreement pursuant to which we have agreed to sell certain software assets and related intellectual property we own to Cognizant. The Cognizant Transaction is subject to receipt of required regulatory approvals. As of December 31, 2014, we have classified $50.0 million, at fair value less cost to sell, in assets as assets held for sale in connection with the Cognizant Transaction.

On April 1, 2012, we completed the sale of the business operations of our Medicare PDP business to CVS Caremark. As a result of the sale, the operating results of our Medicare PDP business have been classified as discontinued operations in our consolidated statements of operations for the year ended December 31, 2012.

See Note 3 for more information on the Cognizant Transaction and the sale of our Medicare PDP business.

Use of Estimates

The preparation of financial statements in conformity with United States Generally Accepted Accounting Principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities through the date of the issuance of the financial statements, and the reported amounts of revenues and expenses during the reporting period. These estimates require the Company to apply complex assumptions and judgments, and often the Company must make estimates about effects of matters that are inherently uncertain and will likely change in subsequent periods. Actual results could differ materially from those estimates. Principal areas requiring the use of estimates include revenue recognition, including rebates, health care costs, including incurred but not yet reported ("IBNR") amounts, amounts receivable or payable under the premium stabilization programs enacted by the ACA (see "Accounting for Certain Provisions of the ACA—3Rs: Reinsurance, Risk Adjustment and Risk Corridor" section below), reserves for contingent liabilities, amounts receivable or payable under government contracts, goodwill and other intangible assets, recoverability of long-lived assets and investments, and income taxes.

Health Plan Services Revenue Recognition

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

Under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “ACA”), commercial health plans with medical loss ratios ("MLR") on fully insured products, as calculated as set forth in the ACA, that fall below certain targets are required to rebate ratable portions of their premiums annually. We classify the estimated rebates, if any, as a reduction to Health plan services premiums in our consolidated statement of operations. Estimated rebates for our commercial health plans were $0 for the year ended December 31, 2014. In addition to the rebates for the commercial health plans under the ACA, there is also a medical loss ratio corridor for the California Department of Health Care Services ("DHCS") adult Medicaid expansion members under the state Medicaid program in California ("Medi-Cal") beginning in 2014 and covering an 18-month period. If our MLR for this population is below 85%, then we would have to pay DHCS a rebate. If the MLR is above 95%, then DHCS would have to pay us additional premium. As of December 31, 2014, we have accrued $200.6 million for a MLR rebate with respect to this population payable to DHCS. Accordingly, for the year ended December 31, 2014, we reduced Medicaid premium revenue by $200.6 million. Our Medicaid contract with the state of Arizona contains profit-sharing provisions. Because our Arizona Medicaid profits were in excess of the amount we are allowed to fully retain, we reduced Medicaid premium revenue by $24.7 million for the year ended December 31, 2014. With respect to our Arizona Medicaid contract, the profit corridor receivable balance included in other noncurrent assets as of December 31, 2014 was $2.3 million and the profit corridor payable balance included in accounts payable and other liabilities as of December 31, 2014 was $27.0 million. In addition, certain provisions of the ACA became effective January 1, 2014, including an annual insurance industry premium-based assessment and the establishment of federally facilitated, state and federal partnership or state-based health insurance exchanges coupled with premium stabilization programs. See below in this Note 2 under the heading "Accounting for Certain Provisions of the ACA" for additional information.

Approximately 59%, 50%, and 45% in 2014, 2013 and 2012, respectively, of our health plan services premiums were generated under Medicare, Medicaid/Medi-Cal and dual eligibles contracts, as applicable. These revenues are subject to audit and retroactive adjustment by the respective fiscal intermediaries. Laws and regulations governing these programs, including the Centers for Medicare and Medicaid Services ("CMS") methodology with respect to risk adjustment data validation ("RADV") audits, are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount.

Our Medicare Advantage contracts are with the Centers for Medicare & Medicaid Services ("CMS"). CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. This risk adjustment model results in periodic changes in our risk factor adjustment scores for certain diagnostic codes, which then result in changes to our health plan services premium revenues. Because the recorded revenue is based on our best estimate at the time, the actual payment we receive from CMS for risk adjustment reimbursement settlements may be materially different than the amounts we have initially recognized on our financial statements. The change in our estimate for the risk adjustment revenue related to prior years in the years ended December 31, 2014, 2013 and 2012 increased health plan services premium revenues by $13.1 million, decreased health plan services premium revenues by $9.0 million, and increased health plan services premium revenues by $12.0 million, respectively.

Our revenue from the Medi-Cal program, including seniors and persons with disabilities ("SPD") programs, and other state-sponsored health programs are subject to certain retroactive rate adjustments based on expected and actual health care cost. For the year ended December 31, 2014, retroactive rate adjustments for our SPD and non-SPD members for periods prior to 2014 were not significant. For the year ended December 31, 2013, we recognized $74.3 million of premium revenue as a result of retroactive rate adjustments for our SPD and non-SPD members for periods prior to 2013. For the year ended December 31, 2012, we recognized $21.7 million of premium revenue as a result of retroactive rate adjustments for our SPD and non-SPD members for periods prior to 2012.

In addition, our state-sponsored health care programs in California, including Medi-Cal, SPD programs, the dual eligibles demonstration portion of the California Coordinated Care Initiative that began in April 2014 and Medicaid expansion under federal health care reform that began in January 2014, are subject to retrospective premium adjustments based on certain risk sharing provisions included in our state-sponsored health plans rate settlement agreement described below. We estimate and recognize the retrospective adjustments to premium revenue based upon experience to date under our state-sponsored health care programs contracts. The retrospective premium adjustment is recorded as an adjustment to premium revenue and other noncurrent assets.

On November 2, 2012, we entered into a state-sponsored health plans rate settlement agreement (the "Agreement") with DHCS to settle historical rate disputes with respect to our participation in the Medi-Cal program, for rate years prior to the 2011–2012 rate year. As part of the Agreement, DHCS agreed, among other things, to (1) an extension of all of our Medi-Cal managed care contracts existing as of the date of the Agreement for an additional five years from their then existing expiration dates; (2) retrospective premium adjustments on all of our state-sponsored health care programs, including Medi-Cal, which includes SPDs, Healthy Families, the dual eligibles demonstration portion of the CCI that began in 2014 and the Medi-Cal expansion populations that also began in 2014 (our “state-sponsored health care programs”), which are tracked in a settlement account as discussed in more detail below; and (3) compensate us should DHCS terminate any of our state-sponsored health care programs contracts early.

Effective January 1, 2013, the settlement account (the "Account") was established with an initial balance of zero. The balance in the Account is adjusted annually to reflect retrospective premium adjustments for each calendar year (referenced in the Agreement as a deficit or surplus). A deficit or surplus will result to the extent our actual pretax margin (as defined in the Agreement) on our state-sponsored health care programs is below or above a predetermined pretax margin target. The amount of any deficit or surplus is calculated as described in the Agreement. Cash settlement of the Account will occur on December 31, 2019, except that under certain circumstances the DHCS may extend the final settlement for up to three additional one-year periods (as may be extended, the "Term"). In addition, the DHCS will make an interim partial settlement payment to us if it terminates any of our state-sponsored health care programs contracts early. Upon expiration of the Term, if the Account is in a surplus position, then no monies are owed to either party. If the Account is in a deficit position, then DHCS shall pay the amount of the deficit to us. In no event, however, shall the amount paid by DHCS to us under the Agreement exceed $264 million or be less than an alternative minimum amount as defined in the Agreement.

We estimate and recognize the retrospective adjustments to premium revenue based upon experience to date under our state-sponsored health care programs contracts. The retrospective premium adjustment is recorded as an adjustment to premium revenue and other noncurrent assets. As of December 31, 2014, we had calculated a surplus of $53.4 million under the Agreement and reduced our receivable to zero, reflecting our cumulative estimated retrospective premium adjustment to the Account based on our actual pretax margin for the period beginning on January 1, 2013 and ending on December 31, 2014. As a surplus Account position results in no monies due to either party upon expiration of the Term, we have no receivable and no payable recorded as of December 31, 2014 in connection with the Agreement. As of December 13, 2013, we had calculated and recorded a deficit of $62.9 million, net of a valuation discount in the amount of $4.4 million, reflecting our estimated retrospective premium adjustment to the Account based on our actual pretax margin for the year ended December 31, 2013. As a result of the change in the Account balance calculated during the year ended December 31, 2014, our health plan services premium revenue was reduced by $62.9 million for the year ended December 31, 2014. For the year ended December 31, 2013, we had recorded an increase in our health plan services premium revenue of $62.9 million as a result of the deficit calculated under the Agreement as of December 31, 2013.

Health Plan Services Health Care Cost

The cost of health care services is recognized in the period in which services are provided and includes an estimate of the cost of services that have been incurred but not yet reported. Such costs include payments to primary care physicians, specialists, hospitals and outpatient care facilities, and the costs associated with managing the extent of such care. Our health care cost can also include from time to time remediation of certain claims as a result of periodic reviews by various regulatory agencies.

Our HMOs, primarily in California, generally contract with various medical groups to provide professional care to certain of their 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 we are liable. Professional capitated contracts also generally contain provisions for shared risk and pay-for-performance bonuses, whereby the Company and the medical groups share in the variance between actual costs and predetermined goals. Additionally, we contract with certain hospitals to provide hospital care to enrolled members on a capitated basis. Our HMOs 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.

We estimate the amount of the provision for health care service costs IBNR in accordance with GAAP and using standard actuarial developmental 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, among other things. Our IBNR best estimate also includes a provision for adverse deviation, which is an estimate for known environmental factors that are reasonably likely to affect the required level of IBNR reserves. This provision for adverse deviation is intended to capture the potential adverse development from known environmental factors such as our entry into new geographical markets, changes in our geographic or product mix, the introduction of new customer populations, variation in benefit utilization, disease outbreaks, changes in provider reimbursement, fluctuations in medical cost trend, variation in claim submission patterns and variation in claims processing speed and payment patterns, changes in technology that provide faster access to claims data or change the speed of adjudication and settlement of claims, variability in claim inventory levels, non-standard claim development, and/or exceptional situations that require judgmental adjustments in setting the reserves for claims. As part of our best estimate for IBNR, the provision for adverse deviation recorded at December 31, 2014 and 2013 was approximately $77.7 million and $53.4 million, respectively; the increase was primarily driven by growth in our new products offered under the ACA.

We consistently apply our IBNR estimation methodology from period to period. Our IBNR best estimate is 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. As additional information becomes known to us, we adjust our assumptions accordingly to change our estimate of IBNR. Therefore, if moderately adverse conditions do not occur, evidenced by more complete claims information in the following period, then our prior period estimates will be revised downward, resulting in favorable development. However, any favorable prior period reserve development would increase current period net income only to the extent that the current period provision for adverse deviation is less than the benefit recognized from the prior period favorable development. If moderately adverse conditions occur and are more acute than we estimated, then our prior period estimates will be revised upward, resulting in unfavorable development, which would decrease current period net income. For the year ended December 31, 2014, we had $14.6 million in net favorable reserve developments related to prior years. This reserve development for the year ended December 31, 2014 consisted of $36.6 million in unfavorable prior year development primarily due to the existence of moderately adverse conditions and a release of $51.2 million of the provision for adverse deviation held at December 31, 2013. We believe that the $36.6 million unfavorable development for the year ended December 31, 2014 was primarily due to unanticipated benefit utilization in our commercial business arising from dates of service in the fourth quarter of 2013 as a result of an uncertain environment related to the ACA. For the year ended December 31, 2013, we had $56.2 million in favorable reserve developments related to prior years. We believe this favorable development was primarily due to the absence of moderately adverse conditions. The reserve developments related to prior years for the years ended December 31, 2014 and 2013, when considered together with the provision for adverse deviation recorded as of December 31, 2014 and 2013, respectively, did not have a material impact on our operating results or financial condition.

The majority of the IBNR reserve balance held at the end of each year is associated with the most recent months' incurred services because these are the services for which the fewest claims have been paid. The degree of uncertainty in the estimates of incurred claims is greater for the most recent months' incurred services. Revised estimates for prior periods are determined in each year based on the most recent updates of paid claims for prior periods. Estimates for service costs incurred but not yet reported are subject to the impact of changes in the regulatory environment, economic conditions, changes in claims trends, and numerous other factors. Given the inherent variability of such estimates, the actual liability could differ materially from the amounts estimated.

We assess 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 estimates for 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 cost. As of December 31, 2014 and 2013, respectively, we held no premium deficiency reserves.

Government Contracts

On April 1, 2011, we began delivery of administrative services under our T-3 contract for the TRICARE North Region. The T-3 contract was awarded to us on May 13, 2010, and included five one-year option periods. On March 15, 2014, the DoD exercised the last of these options, which extended the T-3 contract through March 31, 2015. On June 27, 2014, at the DoD's request, we submitted a proposal to add three additional one-year option periods to the T-3 contract. We currently expect negotiations relating to this proposal to conclude on or prior to March 31, 2015. If the negotiations conclude as expected, we expect the DoD to exercise the first of the three one-year options by that date. If all three one-year option periods are ultimately exercised, the T-3 contract would conclude on March 31, 2018.

We provide various types of administrative services under the T-3 contract, including: provider network management, referral management, medical management, disease management, enrollment, customer service, clinical support service, and claims processing. We also provided assistance in the transition into the T-3 contract, and will provide assistance in any transition out of the contract. These services are structured as cost reimbursement arrangements for health care costs plus administrative fees earned in the form of fixed prices, fixed unit prices, and contingent fees and payments based on various incentives and penalties.

In accordance with GAAP, we evaluate, at the inception of the contract and as services are delivered, all deliverables in the service arrangement to determine whether they represent separate units of accounting. The delivered items are considered separate units of accounting if the delivered items have value to the customer on a standalone basis (i.e., they are sold separately by any vendor) and no general right of return exists relative to the delivered item. While we identified two separate units of accounting within the T-3 contract, no determination of estimated selling price was performed because both units of accounting are performed ratably over the option periods and, accordingly, the same methodology of revenue recognition applies to both units of accounting.

Therefore, we recognize revenue related to administrative services on a straight-line basis over the option period, when the fees become fixed and determinable.

The T-3 contract includes various performance-based incentives and penalties. For each of the incentives or penalties, we adjust revenue accordingly based on the amount that we have earned or incurred at each interim date and are legally entitled to in the event of a contract termination.

The transition-in process for the T-3 contract began in the second quarter of 2010. We had deferred transition-in costs of $43.8 million and related deferred revenues of $52.5 million, both of which are amortized on a straight-line basis over the customer relationship period. Fulfillment costs associated with the T-3 contract are expensed as incurred.

Revenues and expenses associated with the T-3 contract are reported as part of government contracts revenues and government contracts expenses in the consolidated statements of operations and included in the Government Contracts reportable segment.

The TRICARE members are served by our network and out-of-network providers in accordance with the T-3 contract. We pay health care costs related to these services to the providers and are later reimbursed by the DoD for such payments. Under the terms of the T-3 contract, we are not the primary obligor for health care services and accordingly, we do not include health care costs and related reimbursements in our consolidated statement of operations. Health care costs for the T-3 contract that are paid and reimbursed or reimbursable amounted to $2.5 billion, $2.5 billion and $2.6 billion for the years ended December 31, 2014, 2013 and 2012, respectively.

Other government contracts revenues are recognized in the month in which the eligible beneficiaries are entitled to health care services or in the month in which the administrative services are performed or the period that coverage for services is provided.

Amounts receivable under government contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract. Pursuant to our T-3 contract, the government has the right to unilaterally modify the contract in certain respects by issuing change orders directing us to implement terms or services that were not originally included in the contract. Following receipt of a change order, we have a contractual right to negotiate an equitable adjustment to the contract terms to account for the impact of the change order. We start to perform under such change orders and begin to incur associated costs after we receive the government's unilateral modification, but before we have negotiated the final scope and/or value of the change order. In these situations, costs are expensed as incurred, and we estimate and record revenue when we have met all applicable revenue recognition criteria. These criteria include the requirements that change order amounts are determinable, that we have performed under the change orders, and that collectability of amounts payable to us is reasonably assured.

In addition to the beneficiaries that we service under the T-3 contract, we provide behavioral health services to military families under the DoD sponsored MFLC program. On August 15, 2012, we entered into a new MFLC contract awarded by the DoD. The new contract has a five-year term that includes a 12-month base period and four 12-month option periods. As a result of the government's decision to award the new MFLC contract to multiple contractors, the revenues we receive from the new contract are substantially reduced in comparison to the original MFLC contract. Revenues from the MFLC contracts were $119.7 million, $104.8 million and $221.3 million for the years ended December 31, 2014, 2013 and 2012, respectively.

In September 2013, the U.S. Department of Veterans Affairs (“VA”) awarded us a contract under its new Patient Centered Community Care program (“PC3 Program”). The PC3 Program provides eligible veterans coordinated, timely access to care through a comprehensive network of non-VA providers who meet VA quality standards when a local VA medical center cannot readily provide the care. We support VA in providing care to veterans in three of the six PC3 Program regions. These three regions, Regions 1, 2 and 4, encompass all or portions of 37 states, the District of Columbia, Puerto Rico and the Virgin Islands. The PC3 Program contract term includes a base period of performance through September 30, 2014 and four one-year option periods that may be exercised by VA. On September 23, 2014, VA exercised option period 1 which commenced on October 1, 2014 and is scheduled to end on September 30, 2015. In addition to the one-year option periods, VA has the ability to extend the PC3 Program contract an additional two years and six months based on VA's need.

In August 2014, VA expanded our PC3 Program contract to include primary care services for veterans who are unable to obtain primary care at a VA medical center in the three PC3 regions in which we operate. In addition, in November 2014, we modified our PC3 Program contract to further expand our services with VA in support of the Veterans Access, Choice and Accountability Act of 2014 ("VACAA"). The VACAA modification to our PC3 Program contract (the "VACAA modification") expires no later than September 30, 2017. The VACAA modification includes, among other things, the production and distribution of the new Veterans Choice Card, which allows veterans to elect to receive care outside of the VA when they qualify. The transition-in process for the VACAA modification began in the fourth quarter of 2014. We had deferred revenues associated with the contract modification of $68.2 million as of December 31, 2014, which are amortized on a straight-line basis over the customer relationship period. Fulfillment costs associated with the PC3 contract and the related modification are expensed as incurred. For the year ended December 31, 2014, we had $24.7 million in revenues from the PC3 Program.

Divested Operations and Services

Divested operations and services revenues and expenses include items related to the run-out of our Northeast business that was sold in the Northeast Sale on December 11, 2009 and the transition-related services provided in connection with the sale of our Medicare PDP business on April 1, 2012. As of December 31, 2012, we had substantially completed the administration and run-out of our divested businesses. See Note 3 for additional information regarding the Northeast Sale and the sale of our Medicare PDP business, and see Note 14 for information regarding our reportable segments.

Medicare Part D

We provide the Medicare Part D benefit as a fully insured product to our existing Medicare members. The Part D benefit consists of pharmacy benefits for Medicare beneficiaries. Part D renewal occurs annually, but it is not a guaranteed renewable product. We report Part D as part of our Western Region Operations reportable segment. On April 1, 2012, we completed the sale of our Medicare PDP business. In connection with the transaction, we were not permitted to offer Medicare PDP plans for one year following closing, subject to certain exceptions. For more information regarding the sale of our Medicare PDP business, see Note 3. We continue to provide prescription drug benefits as part of our Medicare Advantage offerings. Our Medicare Advantage Plus Prescription Drug ("MAPD") plans cover both prescription drugs and medical care.

Health Net has two primary categories of contracts under Part D, one with CMS and one with the individual Part D enrollees. The CMS contract covers the portion of the revenue for benefits that will be paid by CMS. The enrollee contract covers the portion of the revenue for benefits to be paid by the enrollees and are directly underwritten with the enrollees, not CMS, and therefore there is a direct insurance relationship with the enrollees. The premiums for the enrollee contracts are received directly from the enrollees and from CMS for low-income subsidy members.

The revenue recognition of the revenue and cost reimbursement components under Part D is described below:

CMS Premium Direct Subsidy—Health Net receives a monthly premium from CMS based on an original bid amount. This payment for each individual is a fixed amount per member for the entire plan year and is based upon that individual's risk score status. The CMS premium is recognized evenly over the contract period and reported as part of health plan services premium revenue.

Member Premium—Health Net receives a monthly premium from members based on the original bid submitted to CMS. The member premium, which is fixed for the entire plan year is recognized evenly over the contract period and reported as part of health plan services premium revenue.

Low-Income Premium Subsidy—For qualifying low-income members, CMS will reimburse Health Net, on the member's behalf, some or all of the monthly member premium depending on the member's income level in relation to the Federal Poverty Level. The low-income premium subsidy is recognized evenly over the contract period and reported as part of health plan services premium revenue.

Catastrophic Reinsurance Subsidy—CMS will reimburse Health Net for 80% of the drug costs after a member reaches his or her out of pocket catastrophic threshold of $4,550, $4,750 and $4,700 for the years ended December 31, 2014, 2013 and 2012, respectively. The CMS prospective payment (a flat per member per month ("PMPM") cost reimbursement estimate) is received monthly based on the original CMS bid. After the year is complete, a settlement is made based on actual experience. The catastrophic reinsurance subsidy is accounted for as deposit accounting.

Low-Income Member Cost Sharing Subsidy—For qualifying low-income members, CMS will reimburse us, on the member's behalf, some or all of a member's cost sharing amounts (e.g., deductible, co-pay/coinsurance). The amount paid for the member by CMS is dependent on the member's income level in relation to the Federal Poverty Level. We receive prospective payments on a monthly basis, and they represent a cost reimbursement that is finalized and settled after the end of the year. The low-income member cost sharing subsidy is accounted for as deposit accounting.

Coverage Gap Discount—The Medicare Coverage Gap Discount is a program that began in 2011 under which drug manufacturers are required to provide a 50% discount on brand name drugs purchased in the Medicare Part D coverage gap by non-LIS ("Low Income Subsidy") Part D members. The amount of the discount is included in the accumulation of the members' out-of-pocket costs. Under the Medicare Coverage Gap Discount Program, we receive monthly prospective payments from CMS for advancing the gap discounts at the point of sale. CMS coordinates the collection of discount payments from pharmaceutical manufacturers and payments to Health Net based on prescription drug event data.

CMS Risk Share—Premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by us may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. We estimate and recognize an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility status differences with CMS. The risk-share adjustment, if any, is recorded as an adjustment to premium revenues and premiums receivable.

Health care costs and general and administrative expenses associated with Part D are recognized as the costs and expenses are incurred.

Share-Based Compensation Expense

As of December 31, 2014, we had various long-term incentive plans that permit the grant of stock options and other equity awards to certain employees, officers and non-employee directors, which are described more fully in Note 8.

The compensation cost that has been charged against income under our various long-term incentive plans was $28.3 million, $29.9 million and $28.9 million during the years ended December 31, 2014, 2013 and 2012, respectively. The total income tax benefit recognized in the income statement for share-based compensation arrangements was $10.9 million, $11.6 million and $11.2 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Cash flows resulting from the tax deductions in excess of the compensation cost recognized for those options (excess tax benefits) are classified as financing cash flows and such amounts are approximately $2.2 million, $0.6 million and $6.1 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Forfeiture rates for share based awards are estimated up front and true-up adjustments are recorded for the actual forfeitures.

Cash and Cash Equivalents

Cash equivalents include all highly liquid investments with maturity of three months or less when purchased. We had no checks outstanding, net of deposits as of December 31, 2014 and 2013, respectively. Checks outstanding, net of deposits are classified as accounts payable and other liabilities in the consolidated balance sheets and the changes are reflected in the line item net increase (decrease) in checks outstanding, net of deposits within the cash flows from financing activities in the consolidated statements of cash flows.

Investments

Investments classified as available-for-sale, which consist primarily of debt securities, are stated at fair value. Unrealized gains and losses are 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 net investment income. We analyze all debt investments that have unrealized losses for impairment consideration and assess the intent to sell such securities. If such intent exists, impaired securities are considered other-than-temporarily impaired. Management also assesses if we may be required to sell the debt investments prior to the recovery of amortized cost, which may also trigger an impairment charge. If securities are considered other-than-temporarily impaired based on intent or ability, we assess whether the amortized costs of the securities can be recovered. If management anticipates recovering an amount less than the amortized cost of the securities, an impairment charge is calculated based on the expected discounted cash flows of the securities. Any deficit between the amortized cost and the expected cash flows is recorded through earnings as a charge. All other temporary impairment charges are recorded through other comprehensive income. During the years ended December 31, 2014, 2013 and 2012, no losses were recognized from other-than-temporary impairments.

Fair Value of Financial Instruments

The estimated fair value amounts of cash equivalents, investments available-for-sale, premiums and other receivables, notes receivable and notes payable have been determined by using available market information and appropriate valuation methodologies. The carrying amounts of cash equivalents approximate fair value due to the short maturity of those instruments. Fair values for debt and equity securities are generally based upon quoted market prices. Where quoted market prices were not readily available, fair values were estimated using valuation methodologies based on available and observable market information. Such valuation methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly traded companies in a similar line of business, and reviewing the underlying financial performance including estimating discounted cash flows. The carrying value of premiums and other receivables, long-term notes receivable and nonmarketable securities approximates the fair value of such financial instruments. 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 us for debt with the same remaining maturities. The fair value of our fixed-rate borrowings was $437.0 million and $434.5 million as of December 31, 2014 and 2013, respectively. The fair value of our variable-rate borrowings under our revolving credit facility was $100.0 million and $100.0 million as of December 31, 2014 and 2013, respectively, which was equal to the carrying value because the interest rates paid on these borrowings were based on prevailing market rates. The fair value of our fixed-rate borrowings was determined using the quoted market price, which is a Level 1 input in the fair value hierarchy. The fair value of our variable-rate borrowings was estimated to equal the carrying value because the interest rates paid on these borrowings were based on prevailing market rates. Since the pricing inputs are other than quoted prices and fair value is determined using an income approach, our variable-rate borrowings are classified as a Level 2 in the fair value hierarchy. See Notes 6 and 7 for additional information regarding our financing arrangements and fair value measurements, respectively.

Restricted Assets

We and our consolidated subsidiaries are required to set aside certain funds which may only be used for certain purposes pursuant to state regulatory requirements. We have discretion as to whether we invest such funds in cash and cash equivalents or other investments. As of December 31, 2014 and 2013, the restricted cash and cash equivalents balances totaled $0.2 million and $5.3 million, respectively, and are included in other noncurrent assets. Investment securities held by trustees or agencies were $24.0 million and $23.8 million as of December 31, 2014 and 2013, respectively, and are included in investments available-for-sale. For additional information on our regulatory requirements, see Note 12.

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 remaining lease term, in the case of leasehold improvements. 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 3 to 10 years (see Note 5).

We capitalize certain consulting costs, payroll and payroll-related costs for employees associated with computer software developed for internal use. We amortize such costs primarily over a five-year period. 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.

We periodically assess long-lived assets or asset groups including property and equipment for recoverability when events or changes in circumstances indicate that their carrying amount may not be recoverable. If we identify an indicator of impairment, we assess recoverability by comparing the carrying amount of the asset to the sum of the undiscounted cash flows expected to result from the use and the eventual disposal of the asset. An impairment loss is recognized when the carrying amount is not recoverable and is measured as the excess of carrying value over fair value. Long-lived assets are classified as held for sale and included as part of current assets when certain criteria are met. We measure long-lived assets to be disposed of by sale at the lower of carrying amount or fair value less cost to sell. Fair value is determined using quoted market prices or the anticipated cash flows discounted at a rate commensurate with the risk involved.

In connection with the Cognizant Transaction, we classified certain software systems assets as held-for-sale. As of December 31, 2014, we had classified software systems assets with a total net book value of $130.2 million as assets held for sale. We assessed the recoverability of these assets held for sale and as a result, we recorded $80.2 million in asset impairments during the year ended December 31, 2014. See Note 3 for more information regarding assets held for sale and the Cognizant Transaction. In addition, we recorded an asset impairment of $1.3 million during the year ended December 31, 2014 for internally developed software.

During the years ended December 31, 2013 and 2012, we recorded $1.2 million and $0.5 million respectively, in impairment losses to general and administrative expenses primarily for internally developed software.

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 primarily consist of the value of provider networks and customer relationships, which are all subject to amortization.

We perform our annual impairment test on our recorded goodwill as of June 30 or more frequently if events or changes in circumstances indicate that we might not recover the carrying value of these assets for each of our reporting units. We performed our annual impairment test on our goodwill and other intangible assets as of June 30, 2014 for our Western Region Operations reporting unit and also re-evaluated the useful lives of our other intangible assets. No impairment was identified. We performed a two-step impairment test to determine the existence of impairment and the amount of the impairment. In the first step, we compared the fair values to the related carrying values and concluded that the carrying value of the Western Region Operations was not impaired. As a result, the second step was not performed. We also determined that the estimated useful lives of our other intangible assets properly reflected the current estimated useful lives.

On November 2, 2014, we signed a definitive master services agreement with Cognizant to provide certain services to us. In connection with this agreement, we have agreed to sell certain software assets and related intellectual property ("software system assets") we own to Cognizant. The transaction, including the related asset sale, is subject to the receipt of required regulatory approvals. See Note 3 for additional information regarding our agreements with Cognizant. Because the sale of these software system assets meets the definition of a sale of a business under GAAP, as of September 30, 2014, we re-allocated $7 million of goodwill based on relative fair values of the Western Region Operations reporting unit with and without the impact of the business to be sold. Our measurement of fair values is based on a combination of the discounted total consideration expected to be received in connection with the services and asset sale agreements, income approach based on a discounted cash flow methodology, and replacement cost methodology. After the reallocation of goodwill, we performed a two-step impairment test to determine the existence of any impairment and the amount of the impairment. In the first step, we compared the fair values to the related carrying value and concluded that the carrying value of the business to be sold was impaired; however, we determined that the carrying value of the Western Region Operations reporting unit was not impaired. In the second step, we measured the impairment amount by comparing the implied value of the allocated goodwill to the carrying amount of such goodwill. Based on the results of our Step 2 test, we concluded that the implied value of the goodwill allocated to the business to be sold was zero, which resulted in an impairment charge for the total carrying value of the allocated goodwill of $7 million. See Note 7 for goodwill fair value measurement information.

The ratio of the fair value of our Western Region Operations reporting unit to its carrying value was approximately 224% and 149% as of September 30, 2014 and June 30, 2013, respectively.

The carrying amount of goodwill by reporting unit is as follows:

	Western Region Operations	Total
	(Dollars in millions)	
Balance as of December 31, 2012	$ 565.9	$ 565.9
Balance as of December 31, 2013	565.9	565.9
Goodwill allocated to sale of business (see Note 3)	(7.0)	(7.0)
Balance as of December 31, 2014	$ 558.9	$ 558.9

The intangible assets that continue to be subject to amortization using the straight-line method over their estimated lives are as follows:

	Gross Carrying Amount	Accumulated Amortization	Net Balance	Weighted Average Life (in years)
	(Dollars in millions)			
As of December 31, 2014:				
Provider networks	$ 41.5	$ (36.9)	$ 4.6	18.9
Customer relationships and other	29.5	(22.3)	7.2	11.1
	$ 71.0	$ (59.2)	$ 11.8	
As of December 31, 2013:				
Provider networks	$ 40.5	$ (35.7)	$ 4.8	19.4
Customer relationships and other	29.5	(20.5)	9.0	11.1
	$ 70.0	$ (56.2)	$ 13.8	

The amortization expense was $3.0 million, $3.4 million and $3.4 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Estimated annual pretax amortization expense for other intangible assets for each of the next five years ending December 31 is as follows (dollars in millions):

Year	Amount
2015	$ 2.8
2016	2.2
2017	2.2
2018	2.1
2019	0.9

Policy Acquisition Costs

Policy acquisition costs are those variable costs that relate to the acquisition of new and renewal commercial health insurance business. Such costs include broker commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new commercial business or renew existing business. Our commercial health insurance business typically has a one-year term and may be canceled upon a 30-day notice. We expense these costs as incurred and report them as selling expenses in our consolidated statements of operations.

Reserves for Contingent Liabilities

In the course of our operations, we are involved on a routine basis in various disputes with members, health care providers, and other entities or individuals, as well as audits or investigations by government agencies and elected officials that relate to our services and/or business practices that expose us to potential losses.

We recognize an estimated loss, which may represent damages, assessment of regulatory fines or penalties, settlement costs, future legal expenses or a combination of the foregoing, as appropriate, from such loss contingencies when it is both probable that a loss will be incurred and the amount of the loss can be reasonably estimated. Our loss estimates are based in part on an analysis of potential results, the stage of the proceedings, consultation with outside counsel and any other relevant information available. See Note 13 for additional details.

Insurance Programs

The Company is insured for various errors and omissions, property, casualty and other risks. The Company maintains various self-insured retention amounts, or “deductibles,” on such insurance coverage.

Concentrations of Credit Risk

Financial instruments that potentially subject us 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 provide us diversity among issuers. Our 10 largest employer group premiums receivable balances within each of our plans accounted for 5% and 14% of our total premiums receivable as of December 31, 2014 and 2013, respectively. Our Medicare receivable from CMS represented 9% of total receivables as of December 31, 2014 compared with 21% as of December 31, 2013. Our Medicaid receivable, due primarily from DHCS, represented approximately 84% and 63% of premiums receivable as of December 31, 2014 and 2013, respectively. Our premiums receivable from Medicare and Medicaid programs are subject to timing of cash receipts from the federal and state governmental agencies. Our 10 largest employer group premiums within each of our plans accounted for 11%, 16% and 17% of our health plan services premium revenues for the years ended December 31, 2014, 2013 and 2012, respectively.

The federal government is the primary customer of our Government Contracts reportable segment representing approximately 96% of our Government Contracts revenue. In addition, the federal government is a significant customer of our Western Region Operations segment as a result of our contract with CMS for coverage of Medicare-eligible individuals. Medicare revenues accounted for 23%, 27% and 27% of our health plan premium revenues in 2014, 2013 and 2012, respectively. Our Medicaid revenue is derived in California through our contracts with the DHCS, and, beginning in the fourth quarter of 2013, in Arizona through our contract with the Arizona Health Care Cost Containment System ("AHCCCS"). Medicaid premium revenues accounted for 36%, 23%, and 19% of our health plan services premium revenues for the years ended December 31, 2014, 2013, and 2012, respectively. We are the sole commercial plan contractor with DHCS to provide Medi-Cal services in Los Angeles County, California. In 2014 and 2013, revenue from our Medi-Cal contract in Los Angeles County was approximately 55% and 46% of our total Medicaid premium revenue, respectively, and approximately 19% and 11% of total health plan premium revenue, respectively.

In May 2005, we renewed our contract with DHCS to provide Medi-Cal service in Los Angeles County. On March 29, 2010, DHCS executed an amendment to extend our contract for a second 24-month extension period ending March 31, 2012. On December 1, 2011, our contract with DHCS was extended for a third 24-month period ending March 31, 2014. On November 2, 2012, our wholly owned subsidiaries, Health Net of California, Inc. and Health Net Community Solutions, Inc., entered into a settlement agreement ("the Agreement") with the DHCS. As part of the Agreement, DHCS agreed, among other things, to the extension of all of our Medi-Cal managed care contracts existing on the date of the Agreement, including our contract with DHCS to provide Medi-Cal services in Los Angeles County, for an additional five years from their then existing expiration dates, subject to customary provisions for termination. Accordingly, our Medi-Cal contract for Los Angeles County is scheduled to expire in April 2019. For additional information on our Agreement with DHCS, see "Health Plan Services Revenue Recognition" above in this Note 2.

Earnings Per Share

Basic earnings per share excludes dilution and reflects net income divided by the weighted average shares of common stock outstanding during the periods presented. Diluted earnings per share is based upon the weighted average shares of common stock and dilutive common stock equivalents (this reflects the potential dilution that could occur if stock options were exercised and restricted stock units ("RSUs") and performance share units ("PSUs") were vested) outstanding during the periods presented.

The inclusion or exclusion of common stock equivalents arising from stock options, RSUs and PSUs in the computation of diluted earnings per share is determined using the treasury stock method. For the years ended December 31, 2014, 2013 and 2012, respectively, 1,175,000 shares, 949,000 shares and 954,000 shares of dilutive common stock equivalents were outstanding and were included in the computation of diluted earnings per share.

For the years ended December 31, 2014, 2013 and 2012, respectively, an aggregate of 715,000 shares, 941,000 shares and 1,539,000 shares of common stock equivalents were considered anti-dilutive and were not included in the computation of diluted earnings per share. Stock options expire at various times through August 2018 (see Note 8).

In May 2011, our Board of Directors authorized a stock repurchase program for the repurchase of up to $300 million of our outstanding common stock (our "stock repurchase program"). On March 8, 2012, our Board of Directors approved a $323.7 million increase to our stock repurchase program and on December 16, 2014, our Board of Directors approved another $257.8 million increase to our stock repurchase program. This latest increase, which when taken together with the remaining authorization at that time, brought our total authorization up to $400.0 million. As of December 31, 2014 and 2013, the remaining authorization under our stock repurchase program was $400.0 million and $280.0 million, respectively. See Note 9 for more information regarding our stock repurchase program.

Comprehensive Income

Comprehensive income includes all changes in stockholders' equity (except those arising from transactions with stockholders) and includes net income (loss), net unrealized appreciation (depreciation) after tax on investments available-for-sale and prior service cost and net loss related to our defined benefit pension plan (see Note 10).

Our accumulated other comprehensive income (loss) for the years ended December 31, 2014, 2013 and 2012 is as follows:

	Unrealized Gains (Losses) on investments available-for-sale	Defined Benefit Pension Plans	Accumulated Other Comprehensive Income (loss)
		(Dollars in millions)	
Balance as of January 1, 2012	$ 29.8	$ (13.2)	$ 16.6
Other comprehensive income (loss) before reclassifications	32.1	(0.4)	31.7
Amounts reclassified from accumulated other comprehensive income	(23.9)	2.6	(21.3)
Other comprehensive income for the year ended December 31, 2012	8.2	2.2	10.4
Balance as of January 1, 2013	$ 38.0	$ (11.0)	$ 27.0
Other comprehensive (loss) income before reclassifications	(50.7)	4.8	(45.9)
Amounts reclassified from accumulated other comprehensive income	(15.6)	1.6	(14.0)
Other comprehensive (loss) income for the year ended December 31, 2013	(66.3)	6.4	(59.9)
Balance as of January 1, 2014	$ (28.3)	$ (4.6)	$ (32.9)
Other comprehensive income (loss) before reclassifications	38.3	(7.3)	31.0
Amounts reclassified from accumulated other comprehensive income	(1.8)	0.4	(1.4)
Other comprehensive income (loss) for the year ended December 31, 2014	36.5	(6.9)	29.6
Balance as of December 31, 2014	$ 8.2	$ (11.5)	$ (3.3)

The following table shows reclassifications out of accumulated other comprehensive income and the affected line items in the consolidated statements of operations for the years ended December 31, 2014, 2013 and 2012:

	Year Ended December 31, 2014	2013	2012	Affected line item in the Consolidated Statements of Operations
	(Dollars in millions)			
Unrealized gains on investments available-for-sale	$ 2.7	$ 24.0	$ 36.7	Net investment income
	2.7	24.0	36.7	Total before tax
	0.9	8.4	12.8	Tax expense
	1.8	15.6	23.9	Net of tax
Amortization of defined benefit pension items:				
Prior-service cost	(0.4)	(0.1)	(0.1)	(a)
Actuarial gains (losses)	(0.2)	(2.5)	(4.1)	(a)
	(0.6)	(2.6)	(4.2)	Total before tax
	(0.2)	(1.0)	(1.6)	Tax benefit
	(0.4)	(1.6)	(2.6)	Net of tax
Total reclassifications for the period	$ 1.4	$ 14.0	$ 21.3	Net of tax

____
(a) These accumulated other comprehensive income components are included in the computation of net periodic pension cost.

Taxes Based on Premiums

We provide services in certain states which require premium taxes to be paid by us based on membership or billed premiums. These taxes are paid in lieu of or in addition to state income taxes and totaled $191.2 million in 2014, $124.4 million in 2013 and $51.6 million in 2012. The 2013 premium tax expense includes Medicaid premium taxes reinstated in June 2013 retroactive to July 1, 2012 (see "Medicaid Premium Taxes" below for additional information). These amounts are recorded in general and administrative expenses on our consolidated statements of operations.

Medicaid Premium Taxes

On June 27, 2013, the State of California reinstated premium taxes retroactive to July 1, 2012 for plans participating in Medi-Cal. As a result of this reinstatement, for the year ended December 31, 2013, we recorded $92.8 million, including $20.2 million attributable to periods prior to 2013, as general and administrative expense. In addition, the State of California increased Medicaid premium revenues in an amount equal to the increase in the premium taxes. As a result, we recorded $92.8 million in health plan services premiums for the year ended December 31, 2013. For the year ended December 31, 2014, we recorded $157.1 million in Medicaid premium taxes and a corresponding $157.1 million in health plan services premiums. These Medicaid premium taxes are currently authorized by the State of California through July 1, 2016.

Income Taxes

We record 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. We establish a valuation allowance in accordance with the provisions of the Income Taxes Topic of the Financial Accounting Standards Board ("FASB") codification. We continually review the adequacy of the valuation allowance and recognize the benefits from our deferred tax assets only when an analysis of both positive and negative factors indicate that it is more likely than not that the benefits will be realized.

We file tax returns in many tax jurisdictions. Often, application of tax rules within the various jurisdictions is subject to differing interpretation. Despite our belief that our tax return positions are fully supportable, we believe that it is probable certain positions will be challenged by taxing authorities, and we may not prevail on all of the positions as filed. Accordingly, we maintain a liability for the estimated amount of contingent tax challenges by taxing authorities upon examination. We analyze the amount at which each tax position meets a “more likely than not” standard for sustainability upon examination by taxing authorities. Only tax benefit amounts meeting or exceeding this standard will be reflected in tax provision expense and deferred tax asset balances. Any difference between the amounts of tax benefits reported on tax returns and tax benefits reported in the financial statements is recorded as a liability for unrecognized tax benefits. The liability for unrecognized tax benefits is reported separately from deferred tax assets and liabilities and classified as current or noncurrent based upon the expected period of payment. See Note 11 for additional disclosures.

Accounting for Certain Provisions of the ACA

Premium-based Fee on Health Insurers

The ACA mandated significant reforms to various aspects of the U.S. health insurance industry. Among other things, the ACA imposes an annual premium-based fee on health insurers (the "health insurance industry fee") for each calendar year beginning on or after January 1, 2014 which is not deductible for federal income tax purposes and in many state jurisdictions. The health insurance industry fee is levied based on a ratio of an insurer's net health insurance premiums written for the previous calendar year compared to the U.S. health insurance industry total. We are required to estimate a liability for our portion of the health insurance industry fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the calendar year that it is payable.

In September 2014, we paid the federal government $141.4 million for our portion of the health insurance industry fee in accordance with the ACA. We had recorded a liability for this fee in other current liabilities with an offsetting deferred cost in other current assets in our consolidated financial statements. Our general and administrative expense for the year ended December 31, 2014 includes amortization of the deferred cost of $141.4 million. The balance of the remaining deferred cost asset was $0 as of December 31, 2014.

Public Health Insurance Exchanges

The ACA requires the establishment of state-based, state and federal partnership or federally facilitated health insurance exchanges ("exchanges") where individuals and small groups may purchase health insurance coverage under regulations established by U.S. Department of Health and Human Services ("HHS"). We currently participate in exchanges in Arizona and California. Effective January 1, 2014, the ACA includes permanent and temporary premium stabilization provisions for transitional reinsurance, permanent risk adjustment, and temporary risk corridors (collectively referred to as the "3Rs"), which are applicable to those insurers participating inside, and in some cases outside, of the exchanges.

Member Related Components

Member Premium—We receive a monthly premium from members. The member premium, which is fixed for the entire plan year, is recognized evenly over the contract period and reported as part of health plan services premium revenue.

HEALTH NET, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Premium Subsidy—For qualifying low-income members, HHS will reimburse us, on the member's behalf, some or all of the monthly member premium depending on the member's income level in relation to the Federal Poverty Level. We recognize the premium subsidy evenly over the contract period and report it as part of health plan services premium revenue.

Cost Sharing Subsidy—For qualifying low-income members, HHS will reimburse us, on the member's behalf, some or all of a member's cost sharing amounts (e.g., deductible, co-pay/coinsurance). The amount paid for the member by HHS is dependent on the member's income level in relation to the Federal Poverty Level. The Cost Sharing Subsidy offsets health care costs when incurred. We record a liability if the Cost Sharing Subsidy is paid in advance or a receivable if incurred health care costs exceed the Cost Sharing Subsidy received to date.

3Rs: Reinsurance, Risk Adjustment and Risk Corridor

Our accounting estimates are impacted as a result of the provisions of the ACA, including the 3Rs. The substantial influx of previously uninsured individuals into the new health insurance exchanges under the ACA could make it more difficult for health insurers, including us, to establish pricing accurately, at least during the early years of the exchanges. The 3Rs are intended to mitigate some of the risks around pricing and lack of information surrounding the previously uninsured. We will experience premium adjustments to our health plan services premium revenues and health plan services expenses based on changes to our estimated amounts related to the 3Rs. Such estimated amounts may differ materially from actual amounts ultimately received or paid under the provisions, which may have a material impact on our consolidated results of operations and financial condition.

Reinsurance—The transitional reinsurance program requires us to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans in the individual commercial market will be eligible for recoveries if individual claims exceed a specified threshold. Accordingly, we account for transitional reinsurance contributions associated with all commercial medical health plans other than non-grandfathered individual plans as an assessment in general and administrative expenses in our consolidated statement of income. We account for contributions made by individual commercial plans which are subject to recoveries as contra-health plan services premium revenue, and we account for any recoveries as contra-health plan services expense in our consolidated statements of income with a corresponding current or long-term receivable or payable. We recorded $234.0 million of reinsurance recovery as contra-health plan services expense for the year ended December 31, 2014, and the balance included in other receivables as of December 31, 2014 was $234.0 million.

Risk Adjustment—The risk adjustment provision applies to individual and small group business both within and outside the exchange and requires measurement of the relative health status risk of each insurer's pool of insured enrollees in a given market. The risk adjustment provision then operates to transfer funds from insurers whose pools of insured enrollees have lower-than-average risk scores to those insurers whose pools have greater-than-average risk scores. Our estimate for the risk adjustment incorporates our risk scores by state and market relative to the market average using data provided by the participating insurers and available information about the HHS model. This information is consistent with our knowledge and understanding of market conditions.

As part of our ongoing estimation process, we consider information as it becomes available at interim dates along with our actuarially determined expectations, and we update our estimates incorporating such information as appropriate.

We estimate and recognize adjustments to our health plan services premium revenue for the risk adjustment provision by projecting our ultimate premium for the calendar year. Such estimated calendar year amounts are recognized ratably during the year and are revised each period to reflect current experience. We record receivables and/or payables and classify the amounts as current or long-term in the consolidated balance sheets based on the timing of expected settlement. Our risk adjustment estimate was $72.4 million net payable for the year ended December 31, 2014, and was recorded as a reduction to health plan services premiums. The risk adjustment receivable balance included in other receivables as of December 31, 2014 was $81.0 million and the risk adjustment payable balance included in accounts payable and other liabilities as of December 31, 2014 was $153.4 million.

Risk Corridor—The temporary risk corridor program will be in place for three years and applies to individual and small group business operating both inside and outside of the exchanges. The risk corridor provisions limit health insurers' gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Variances from the target exceeding certain thresholds may result in HHS making additional payments to us or require us to make payments to HHS.

We estimate and recognize adjustments to our health plan services premium revenue for the risk corridor provision by projecting our ultimate premium for the calendar year. Such estimated calendar year amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk adjustment and reinsurance recoverables. We record receivables or payables and classify the amounts as current or long-term in the consolidated balance sheets based on the timing of expected settlement. For the year ended December 31, 2014,we recorded $86.8 million of increases to risk corridor net receivable as health plan services premium revenue. The risk corridor receivable balance included in other noncurrent assets as of December 31, 2014 was $90.4 million and the risk corridor payable balance included in other noncurrent liabilities as of December 31, 2014 was $3.6 million. HHS recognizes, in both final regulations and guidance, it is obligated to make the risk corridors program payments without regard to budget neutrality. Although HHS anticipates the program will be budget neutral, the ACA requires HHS to make full payments to those issuers with risk corridors ratios above 103 percent. Additionally, HHS states in final regulations and guidance that if the program’s collections, including any potential carryover from prior years, are insufficient to satisfy its payment obligations, the agency will use other sources of funding to meet its payment obligations, subject to the availability of appropriations. If corridor collections are insufficient in 2014, HHS explains that it shall fulfill its obligations for the 2014 benefit year by using funds collected for the 2015 benefit year prior to making payments on 2015 obligations.

The final reconciliation and settlement with HHS of the premium and cost sharing subsidies and the amounts related to the 3Rs for the current year will be completed in the following year with HHS.

Section 1202 of ACA

Section 1202 of the ACA mandates increases in Medicaid payment rates for primary care in calendar years 2013 and 2014. The final rule has been in effect since January 1, 2013. The provisions of section 1202 impact our 1.6 million Medi-Cal members in California and 81,000 Medicaid members in Arizona. DHCS, the agency that regulates the Medi-Cal program, initially implemented a reimbursement methodology with no underwriting risk to the managed care plans ("MCPs") in 2013. Subsequently, DHCS changed the reimbursement methodology during the second quarter of 2014, and this change transferred full underwriting risk to the MCPs.

For the periods prior to this reimbursement methodology change, i.e., the year ended December 31, 2013 and the three months ended March 31, 2014, we accounted for the provisions of section 1202 on an administrative services only basis since it transferred no underwriting risk to the MCPs, and recorded the receipts and payments on a net basis.

Following the change in reimbursement methodology, we have full underwriting risk for 2013, including both utilization and unit cost risk. Accordingly, for the year ended December 31, 2014, with respect to our Medi-Cal business, we:

- Reversed $7.9 million previously recorded as administrative services fees and other income in 2013 and for the three months ended March 31, 2014.
- Recorded payments on a grossed-up basis by recording Medi-Cal payments received as premium revenue and estimated Medi-Cal claim payments as health care costs (incurred claims), each via retroactive adjustments to premium revenues and health care costs.
- Recorded retrospective premium revenue adjustments based upon the state settlement agreement (see Note 2 - "Health Plan Services Revenue Recognition" above).

The financial statement impact of the section 1202 reimbursement methodology change is summarized in the table below.

	Recorded In		
	Year Ended December 31, 2013	Year Ended December 31, 2014	
(Dollars in millions)	No Risk	No Risk	Full Risk
Health plan services premiums	$ 4.4	$ —	$ 154.7
Health plan services expenses	—	—	144.0
General and administrative expenses	4.4	—	—
Administrative services fees and other income	6.5	1.4	(7.9)
Pretax income	$ 6.5	$ 1.4	$ 2.8

Recently Issued Accounting Pronouncement

In May 2014, the Financial Accounting Standards Board issued Accounting Standard Update (ASU) No. 2014-09, “Revenue from Contracts with Customers (Topic 606)” (ASU 2014-09). ASU 2014-09 will supersede existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity’s insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures will be required. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. ASU 2014-09 will become effective for annual and interim reporting periods beginning after December 15, 2016. Early adoption is not permitted. We are currently evaluating the effect of the new revenue recognition guidance.

Note 3—Assets Held For Sale, Sale of Medicare PDP Business and Northeast Business

Assets Held for Sale

On November 2, 2014, we signed a definitive seven-year master services agreement with Cognizant to provide consulting, technology and administrative services to us in the following areas: claims management, membership and benefits configuration, customer contact center services, information technology, quality assurance, appeals and grievance services and non-clinical medical management support. In addition, we have entered into an asset purchase agreement with Cognizant for the sale of certain of our software system assets to Cognizant for $50 million. The transaction, including the related asset purchase (the "Cognizant Transaction"), is expected to close in the first half of 2015, subject to the receipt of required regulatory approvals.

We have determined that the sale of these software system assets constitutes a sale of a business as defined under GAAP, and the requirements to classify these software system assets as held-for-sale were met as of September 30, 2014. Assets held for sale are measured at the lower of carrying value or fair value less cost to sell. Accordingly, we have classified $50.0 million in assets as assets held for sale as of December 31, 2014.

The following table presents the major classes of assets included in this amount (dollars in millions):

	Assets Classified as Held for Sale	Impairment Loss	Assets Held for Sale as of December 31, 2014
Property and equipment, net	$ 130.2	$ (80.2)	$ 50.0
Goodwill allocated to sale of business	7.0	(7.0)	—
Assets held for sale	$ 137.2	$ (87.2)	$ 50.0
Other impaired property and equipment, net		$ (1.3)	
Asset impairment		$ (88.5)	

In connection with the pending sale, we have assessed the recoverability of goodwill and other long-lived assets, including property and equipment. As a result, in the year ended December 31, 2014, we recorded $87.2 million in asset impairments, including goodwill impairment of $7.0 million (see Note 2) and impairment of property and equipment of $80.2 million (see Note 7). In addition, we recorded an asset impairment of $1.3 million during the year ended December 31, 2014 for internally developed software, bringing our total asset impairment to $88.5 million.

Sale of Medicare PDP Business

On April 1, 2012, our subsidiary Health Net Life Insurance Company ("HNL") sold substantially all of the assets, properties and rights of HNL used primarily or exclusively in our Medicare PDP business to CVS Caremark for a total purchase price of $248.2 million. In the year ended December 31, 2012, we recognized a $132.8 million pretax gain on the sale of our Medicare PDP business, or $114.8 million net of tax, and this after tax gain was reported as gain on sale of discontinued operation, net of tax.

In connection with the transaction, we were not permitted to offer Medicare PDP plans for one year following the closing, subject to certain exceptions. We continue to provide prescription drug benefits as part of our Medicare Advantage plan offerings.

In addition, we provided Medicare PDP transition-related services to CVS Caremark in connection with the transaction prior to December 31, 2012, and certain transition-related services were provided in 2013. We recognized the value of future transition-related services to be provided under the Asset Purchase Agreement of $12.0 million as deferred revenue at fair value as of April 1, 2012. This deferred revenue was amortized on a straight-line basis over a nine-month period. Revenues and expenses from these transition-related services are reported as part of divested operations and services revenue and expenses (see Notes 2 and 14).

Our revenues related to our Medicare PDP business were $192.1 million for the year ended December 31, 2012. These revenues were excluded from our continuing operating results and included in loss from discontinued operation. Our Medicare PDP business had a pretax loss of $28.8 million for the year ended December 31, 2012. As of December 31, 2012, 2013 and 2014, we had no Medicare stand-alone prescription drug plan members. We had no revenues and no pretax income from the Medicare PDP business for the years ended December 31, 2013 and 2014.

Northeast Sale

On December 11, 2009, we completed the sale of the Acquired Companies to United. As part of the Northeast Sale, we were required to continue to serve the members of the Acquired Companies and provide certain administrative services to United until July 1, 2011 under administrative services agreements, and we were required to provide run-out support services under claims servicing agreements with United, which will be in effect until the last run out claim under the applicable claims servicing agreement has been adjudicated. All revenues and expenses related to the Northeast Sale, including those relating to the administrative services and/or claims servicing agreements and any revenues and expenses related to the run-out, were reported as part of divested operations and services revenue and expenses.

As of December 31, 2012, we had substantially completed the administration and run-out of our divested businesses.

Note 4—Investments

Investments classified as available-for-sale, which consist primarily of debt securities, are stated at fair value. Unrealized gains and losses are 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 net investment income. We periodically assess our available-for-sale investments for other-than-temporary impairment. Any such other-than-temporary impairment loss is recognized as a realized loss, which is recorded through earnings, if related to credit losses.

During the years ended December 31, 2014 and 2013, we recognized no losses from other-than-temporary impairments of our cash equivalents and available-for-sale investments.

We classified $4.6 million and $59.8 million as investments available-for-sale-noncurrent as of December 31, 2014 and 2013, respectively, because we did not intend to sell and we believed it may take longer than a year for such impaired securities to recover. This classification does not affect the marketability or the valuation of the investments, which are reflected at their market value as of December 31, 2014 and 2013.

As of December 31, 2014 and 2013, the amortized cost, gross unrealized holding gains and losses, and fair value of our current investments available-for-sale and our investments available-for-sale-noncurrent, after giving effect to other-than-temporary impairments were as follows:

	2014			
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Carrying Value
	(Dollars in millions)			
Current:				
Asset-backed securities	$ 437.2	$ 2.6	$ (1.9)	$ 437.9
U.S. government and agencies	36.5	—	—	36.5
Obligations of states and other political subdivisions	716.7	17.2	(1.7)	732.2
Corporate debt securities	587.0	2.7	(5.3)	584.4
	$ 1,777.4	$ 22.5	$ (8.9)	$ 1,791.0
Noncurrent:				
Asset-backed securities	$ 0.8	$ —	$ (0.2)	$ 0.6
Corporate debt securities	4.7	—	(0.7)	4.0
	$ 5.5	$ —	$ (0.9)	$ 4.6

	2013			
	Amortized Cost	Gross Unrealized Holding Gains	Gross Unrealized Holding Losses	Carrying Value
	(Dollars in millions)			
Current:				
Asset-backed securities	$ 394.7	$ 3.4	$ (8.7)	$ 389.4
U.S. government and agencies	23.7	—	—	23.7
Obligations of states and other political subdivisions	734.3	5.9	(30.3)	709.9
Corporate debt securities	449.8	3.6	(9.4)	444.0
	$ 1,602.5	$ 12.9	$ (48.4)	$ 1,567.0
Noncurrent:				
Asset-backed securities	$ 1.3	$ —	$ (0.2)	$ 1.1
Obligations of states and other political subdivisions	53.4	—	(6.3)	47.1
Corporate debt securities	13.2	—	(1.6)	11.6
	$ 67.9	$ —	$ (8.1)	$ 59.8

As of December 31, 2014, the contractual maturities of our current investments available-for-sale and our investments available-for-sale-noncurrent were as follows:

	Amortized Cost	Estimated Fair Value
Current:	(Dollars in millions)	
Due in one year or less	$ 69.4	$ 69.6
Due after one year through five years	357.5	357.8
Due after five years through ten years	486.3	489.6
Due after ten years	427.0	436.1
Asset-backed securities	437.2	437.9
Total current investments available-for-sale	$ 1,777.4	$ 1,791.0

	Amortized Cost	Estimated Fair Value
Noncurrent:	(Dollars in millions)	
Due after one year through five years	1.3	1.1
Due after five years through ten years	3.4	2.9
Asset-backed securities	0.8	0.6
Total noncurrent investments available-for-sale	$ 5.5	$ 4.6

Proceeds from sales of investments available-for-sale during 2014 were $441.4 million. Gross realized gains and losses during 2014 totaled $5.7 million and $3.0 million, respectively. Proceeds from sales of investments available-for-sale during 2013 were $696.5 million. Gross realized gains and losses during 2013 totaled $26.4 million and $2.4 million, respectively. Proceeds from sales of investments available-for-sale during 2012 were $1,350.0 million. Gross realized gains and losses during 2012 totaled $37.2 million and $0.5 million, respectively.

The following tables show our investments' fair values and gross unrealized losses for individual securities that have been in a continuous loss position through December 31, 2014 and December 31, 2013. These investments are interest-yielding debt securities of varying maturities. We have determined that the unrealized loss position for these securities is primarily due to market volatility. Generally, in a rising interest rate environment, the estimated fair value of fixed income securities would be expected to decrease; conversely, in a decreasing interest rate environment, the estimated fair value of fixed income securities would be expected to increase. These securities may also be negatively impacted by illiquidity in the market.

The following table shows our current investments' fair values and gross unrealized losses for individual securities in a continuous loss position as of December 31, 2014:

	Less than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
	(Dollars in millions)					
Asset-backed securities	$ 149.3	$ (0.5)	$ 112.5	$ (1.4)	$ 261.8	$ (1.9)
U.S. government and agencies	20.7	—	—	—	20.7	—
Obligations of states and other political subdivisions	37.3	(0.1)	104.8	(1.6)	142.1	(1.7)
Corporate debt securities	299.1	(3.9)	56.0	(1.4)	355.1	(5.3)
	$ 506.4	$ (4.5)	$ 273.3	$ (4.4)	$ 779.7	$ (8.9)

The following table shows our noncurrent investments' fair values and gross unrealized losses for individual securities that have been in a continuous loss position through December 31, 2014:

	Less than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
	(Dollars in millions)					
Asset-backed securities	$ —	$ —	$ 0.6	$ (0.2)	$ 0.6	$ (0.2)
Corporate debt securities	4.0	(0.7)	—	—	4.0	(0.7)
	$ 4.0	$ (0.7)	$ 0.6	$ (0.2)	$ 4.6	$ (0.9)

The following table shows the number of our individual securities-current that have been in a continuous loss position at December 31, 2014:

	Less than 12 Months	12 Months or More	Total
Asset-backed securities	124	51	175
U.S. government and agencies	4	—	4
Obligations of states and other political subdivisions	21	46	67
Corporate debt securities	320	69	389
	469	166	635

The following table shows the number of our individual securities-noncurrent that have been in a continuous loss position through December 31, 2014:

	Less than 12 Months	12 Months or More	Total
Asset-backed securities	—	1	1
Corporate debt securities	9	—	9
	9	1	10

The following table shows our current investments' fair values and gross unrealized losses for individual securities that have been in a continuous loss position through December 31, 2013:

	Less than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
	(Dollars in millions)					
Asset-backed securities	$ 225.3	$ (7.9)	$ 22.5	$ (0.8)	$ 247.8	$ (8.7)
U.S. government and agencies	4.0	—	—	—	4.0	—
Obligations of states and other political subdivisions	453.5	(23.5)	79.7	(6.8)	533.2	(30.3)
Corporate debt securities	242.8	(9.0)	6.7	(0.4)	249.5	(9.4)
	$ 925.6	$ (40.4)	$ 108.9	$ (8.0)	$ 1,034.5	$ (48.4)

The following table shows our noncurrent investments' fair value and gross unrealized losses for our individual securities that have been in a continuous loss position through December 31, 2013:

	Less than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Asset-backed securities	$ 0.5	$ (0.1)	$ 0.7	$ (0.1)	$ 1.2	$ (0.2)
Obligations of states and other political subdivisions	17.4	(2.2)	29.6	(4.1)	$ 47.0	$ (6.3)
Corporate debt securities	7.5	(0.9)	4.1	(0.7)	$ 11.6	$ (1.6)
	$ 25.4	$ (3.2)	$ 34.4	$ (4.9)	$ 59.8	$ (8.1)

Note 5—Property and Equipment

Property and equipment are comprised of the following as of December 31:

	2014	2013
	(Dollars in millions)	
Land	$ 1.7	$ 1.7
Leasehold improvements under development	1.5	3.9
Buildings and improvements	55.8	52.4
Furniture, equipment and software	210.5	422.2
	269.5	480.2
Less accumulated depreciation	(185.2)	(278.8)
Property and equipment, net	$ 84.3	$ 201.4

In connection with the Cognizant Transaction, we classified certain software system assets as held-for-sale. As of December 31, 2014, we had classified software systems assets with a total net book value of $130.2 million as assets held for sale. See Note 3 for more information regarding assets held for sale and the Cognizant Transaction.

Our depreciation expense was $27.1 million, $35.6 million and $27.9 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Note 6—Financing Arrangements

Revolving Credit Facility

In October 2011, we entered into a $600 million unsecured revolving credit facility due in October 2016, which includes a $400 million sublimit for the issuance of standby letters of credit and a $50 million sublimit for swing line loans (which sublimits may be increased in connection with any increase in the credit facility described below). In addition, we have the ability from time to time to increase the credit facility by up to an additional $200 million in the aggregate, subject to the receipt of additional commitments. As of December 31, 2014, $100.0 million was outstanding under our revolving credit facility and the maximum amount available for borrowing under the revolving credit facility was $491.4 million (see "—Letters of Credit" below).

Amounts outstanding under our revolving credit facility bear interest, at the Company's option, at either (a) the base rate (which is a rate per annum equal to the greatest of (i) the federal funds rate plus one-half of one percent, (ii) Bank of America, N.A.'s "prime rate" and (iii) the Eurodollar Rate (as such term is defined in the credit facility) for a one-month interest period plus one percent) plus an applicable margin ranging from 45 to 105 basis points or (b) the Eurodollar Rate plus an applicable margin ranging from 145 to 205 basis points. The applicable margins are based on our consolidated leverage ratio, as specified in the credit facility, and are subject to adjustment following the Company's delivery of a compliance certificate for each fiscal quarter.

Our revolving credit facility includes, among other customary terms and conditions, limitations (subject to specified exclusions) on our and our subsidiaries' ability to incur debt; create liens; engage in certain mergers, consolidations and acquisitions; sell or transfer assets; enter into agreements that restrict the ability to pay dividends or make or repay loans or advances; make investments, loans, and advances; engage in transactions with affiliates; and make dividends. In addition, we are required to be in compliance at the end of each fiscal quarter with a specified consolidated leverage ratio and consolidated fixed charge coverage ratio. As of December 31, 2014, we were in compliance with all covenants under the revolving credit facility.

Our revolving credit facility contains customary events of default, including nonpayment of principal or other amounts when due; breach of covenants; inaccuracy of representations and warranties; cross-default and/or cross-acceleration to other indebtedness of the Company or our subsidiaries in excess of $50 million; certain ERISA-related events; noncompliance by the Company or any of our subsidiaries with any material term or provision of the HMO Regulations or Insurance Regulations (as each such term is defined in the credit facility) in a manner that could reasonably be expected to result in a material adverse effect; certain voluntary and involuntary bankruptcy events; inability to pay debts; undischarged, uninsured judgments greater than $50 million against us and/or our subsidiaries that are not stayed within 60 days; actual or asserted invalidity of any loan document; and a change of control. If an event of default occurs and is continuing under the revolving credit facility, the lenders thereunder may, among other things, terminate their obligations under the facility and require us to repay all amounts owed thereunder.

Letters of Credit

Pursuant to the terms of our revolving credit facility, we can obtain letters of credit in an aggregate amount of $400 million and the maximum amount available for borrowing is reduced by the dollar amount of any outstanding letters of credit. As of December 31, 2014 and 2013, we had outstanding letters of credit of $8.6 million and $7.5 million, respectively, resulting in a maximum amount available for borrowing of $491.4 million and $492.5 million, respectively. As of December 31, 2014 and 2013, no amounts had been drawn on any of these letters of credit.

Senior Notes

In 2007 we issued $400 million in aggregate principal amount of 6.375% Senior Notes due 2017 ("Senior Notes"). The indenture governing the Senior Notes limits our ability to incur certain liens, or consolidate, merge or sell all or substantially all of our assets. In the event of the occurrence of both (1) a change of control of Health Net, Inc. and (2) a below investment grade rating by any two of Fitch, Inc., Moody's Investors Service, Inc. and Standard & Poor's Ratings Services within a specified period, we will be required to make an offer to purchase the Senior Notes at a price equal to 101% of the principal amount of the Senior Notes plus accrued and unpaid interest to the date of repurchase. As of December 31, 2014, no default or event of default had occurred under the indenture governing the Senior Notes.

The Senior Notes may be redeemed in whole at any time or in part from time to time, prior to maturity at our option, at a redemption price equal to the greater of:

- 100% of the principal amount of the Senior Notes then outstanding to be redeemed; or
- the sum of the present values of the remaining scheduled payments of principal and interest on the Senior Notes to be redeemed (not including any portion of such payments of interest accrued to the date of redemption) discounted to the date of redemption on a semiannual basis (assuming a 360-day year consisting of twelve 30 day months) at the applicable treasury rate plus 30 basis points

plus, in each case, accrued and unpaid interest on the principal amount being redeemed to the redemption date.

Each of the following will be an Event of Default under the indenture governing the Senior Notes:

- failure to pay interest for 30 days after the date payment is due and payable; provided that an extension of an interest payment period by us in accordance with the terms of the Senior Notes shall not constitute a failure to pay interest;
- failure to pay principal or premium, if any, on any note when due, either at maturity, upon any redemption, by declaration or otherwise;
- failure to perform any other covenant or agreement in the notes or indenture for a period of 60 days after notice that performance was required;
- (A) our failure or the failure of any of our subsidiaries to pay indebtedness for money we borrowed or any of our subsidiaries borrowed in an aggregate principal amount of at least $50 million, at the later of final maturity and the expiration of any related applicable grace period and such defaulted payment shall not have been made, waived or extended within 30 days after notice or (B) acceleration of the maturity of indebtedness for money we borrowed or any of our subsidiaries borrowed in an aggregate principal amount of at least $50 million, if that acceleration results from a default under the instrument giving rise to or securing such indebtedness for money borrowed and such indebtedness has not been discharged in full or such acceleration has not been rescinded or annulled within 30 days after notice; or
- events in bankruptcy, insolvency or reorganization of our Company.

Our Senior Notes payable balances were $399.5 million as of December 31, 2014 and $399.3 million as of December 31, 2013.

Note 7—Fair Value Measurements

We record certain assets and liabilities at fair value in the consolidated balance sheets and categorize them based upon the level of judgment associated with the inputs used to measure their fair value and the level of market price observability. We also estimate fair value when the volume and level of activity for the asset or liability have significantly decreased or in those circumstances that indicate when a transaction is not orderly.

Investments measured and reported at fair value using Level inputs are classified and disclosed in one of the following categories:

Level 1—Quoted prices are available in active markets for identical investments as of the reporting date. The types of investments included in Level 1 include U.S. Treasury securities and listed equities. We do not adjust the quoted price for these investments, even in situations where we hold a large position and a sale could reasonably impact the quoted price.

Level 2—Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the reporting date, and fair value is determined through the use of models and/or other valuation methodologies that are based on an income approach. Examples include, but are not limited to, multidimensional relational model, option adjusted spread model, and various matrices. Specific pricing inputs include quoted prices for similar securities in both active and non-active markets, other observable inputs such as interest rates, yield curve volatilities, default rates, and inputs that are derived principally from or corroborated by other observable market data. Investments that are generally included in this category include asset-backed securities, corporate bonds and loans, and state and municipal bonds.

Level 3—Pricing inputs are unobservable for the investment and include situations where there is little, if any, market activity for the investment. The inputs into the determination of fair value require significant management judgment or estimation using assumptions that market participants would use, including assumptions for risk. Level 3 includes an embedded contractual derivative asset and/or liability held by the Company estimated at fair value. Significant inputs used in the derivative valuation model include the estimated growth in Health Net health care expenditures and estimated growth in national health care expenditures. The growth in these expenditures was modeled using a Monte Carlo simulation approach. Level 3 also includes a state-sponsored health plans settlement account deficit asset estimated at fair value based on the income approach. See Note 2 for additional information on our state-sponsored health plans rate settlement agreement.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an investment's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement. Our assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the investment.

The following tables present information about our assets and liabilities measured at fair value on a recurring basis at December 31, 2014 and 2013, and indicate the fair value hierarchy of the valuation techniques utilized by us to determine such fair value (dollars in millions):

	Level 1	Level 2-current	Level 2-noncurrent	Level 3	Total
As of December 31, 2014					
Assets:					
Cash and cash equivalents	$ 869.1	$ —	$ —	$ —	$ 869.1
Investments—available-for-sale					
Asset-backed debt securities:					
Residential mortgage-backed securities	$ —	$ 210.9	$ —	$ —	$ 210.9
Commercial mortgage-backed securities	—	145.6	0.6	—	146.2
Other asset-backed securities	—	81.4	—	—	81.4
U.S. government and agencies:					
U.S. Treasury securities	36.5	—	—	—	36.5
U.S. Agency securities	—	—	—	—	—
Obligations of states and other political subdivisions	—	732.2	—	—	732.2
Corporate debt securities	—	584.4	4.0	—	588.4
Total investments at fair value	$ 36.5	$ 1,754.5	$ 4.6	$ —	$ 1,795.6
Embedded contractual derivative	—	—	—	10.0	10.0
State-sponsored health plans settlement account deficit	—	—	—	—	—
Total assets at fair value	$ 905.6	$ 1,754.5	$ 4.6	$ 10.0	$ 2,674.7

As of December 31, 2014	
Liability:	
Embedded contractual derivative	$ 2.6
Total liability at fair value	$ 2.6

	Level 1	Level 2-current	Level 2-noncurrent	Level 3	Total
As of December 31, 2013					
Assets:					
Cash and cash equivalents	$ 433.2	$ —	$ —	$ —	$ 433.2
Investments—available-for-sale					
Asset-backed debt securities:					
Residential mortgage-backed securities	$ —	$ 203.5	$ 0.4	$ —	$ 203.9
Commercial mortgage-backed securities	—	144.1	0.7	—	144.8
Other asset-backed securities	—	41.8	—	—	41.8
U.S. government and agencies:					
U.S. Treasury securities	23.7	—	—	—	23.7
U.S. Agency securities	—	—	—	—	—
Obligations of states and other political subdivisions	—	709.9	47.1	—	757.0
Corporate debt securities	—	444.0	11.6	—	455.6
Total investments at fair value	$ 23.7	$ 1,543.3	$ 59.8	$ —	$ 1,626.8
Embedded contractual derivative	—	—	—	7.2	7.2
State-sponsored health plans settlement account deficit	—	—	—	62.9	62.9
Total assets at fair value	$ 456.9	$ 1,543.3	$ 59.8	$ 70.1	$ 2,130.1

We had no financial liabilities fair valued on a recurring basis as of December 31, 2013.

We had no transfers between Levels 1 and 2 of financial assets or liabilities that are fair valued on a recurring basis during the years ended December 31, 2014 and 2013. In determining when transfers between levels are recognized, our accounting policy is to recognize the transfers based on the actual date of the event or change in circumstances that caused the transfer.

The changes in the balances of Level 3 financial assets for the years ended December 31, 2014 and 2013 were as follows (dollars in millions):

	Year Ended December 31,							
	2014				2013			
	Available-For-Sale Investments	Embedded Contractual Derivative	State-Sponsored Health Plans Settlement Account Deficit	Total	Available-For-Sale Investments	Embedded Contractual Derivative	State-Sponsored Health Plans Settlement Account Deficit	Total
Opening balance	$ —	$ 7.2	$ 62.9	$70.1	$ 0.2	$ 11.2	$ —	$11.4
Transfers into Level 3	—	—	—	—	—	—	—	—
Transfers out of Level 3	—	—	—	—	—	—	—	—
Total gains or losses for the period:								
Realized in net income	—	2.8	(62.9)	(60.1)	—	5.7	62.9	68.6
Unrealized in accumulated other comprehensive income	—	—	—	—	—	—	—	—
Purchases, issues, sales and settlements:								
Purchases	—	—	—	—	—	—	—	—
Issues	—	—	—	—	—	—	—	—
Sales	—	—	—	—	(0.2)	—	—	(0.2)
Settlements	—	—	—	—	—	(9.7)	—	(9.7)
Closing balance	$ —	$ 10.0	$ —	$ 10.0	$ —	$ 7.2	$ 62.9	$ 70.1
Change in unrealized gains (losses) included in net income for assets held at the end of the reporting period	$—	$—	$—	$ —	$ —	$ —	$—	$ —

The changes in the balance of the Level 3 financial liability for the year ended December 31, 2014 and 2013 were as follows (dollars in millions):

	Year Ended December 31,	
	2014	2013
	Embedded Contractual Derivative	
Opening balance	$ —	$ 3.2
Transfers into Level 3	—	—
Transfers out of Level 3	—	—
Total gains or losses for the period:		
Realized in net income	2.6	(3.2)
Unrealized in accumulated other comprehensive income	—	—
Purchases, issues, sales and settlements:		
Purchases	—	—
Issues	—	—
Sales	—	—
Settlements	—	—
Closing balance	$ 2.6	$ —

As of December 31, 2014, we classified certain assets as assets held for sale. These assets held for sale are carried at the lower of carrying value or fair value (see Note 2, under the heading "Goodwill and Other Intangibles," and Note 3 for additional information). The following table presents information about our assets classified as held for sale as of December 31, 2014, the hierarchy of the valuation techniques utilized by us to determine such fair values and the related impairment loss for the year ended December 31, 2014 (dollars in millions):

	Level 3	Total Asset Impairment for the Year Months Ended December 31, 2014
Property and equipment, net	$ 50.0	$ 80.2
Goodwill allocated to sale of business	—	7.0
Assets held for sale	$ 50.0	$ 87.2

We had no liabilities fair valued on a non-recurring basis during the year ended December 31, 2014. We had no financial assets or liabilities that were fair valued on a non-recurring basis during the year ended December 31, 2013.

The following tables present quantitative information about Level 3 Fair Value Measurements (dollars in millions):

	Fair Value as of December 31, 2014	Valuation Technique(s)	Unobservable Input	Range (Weighted Average)		
Embedded contractual derivative asset	$ 10.0	Monte Carlo Simulation Approach	Health Net Health Care Expenditures	-0.08 % —	2.74%	(2.02%)
			National Health Care Expenditures	3.45 % —	4.14%	(3.80%)
Embedded contractual derivative liability	$ 2.6	Monte Carlo Simulation Approach	Health Net Health Care Expenditures	0.79 % —	10.76%	(5.73%)
			National Health Care Expenditures	0.64 % —	8.43%	(4.38%)
Goodwill - Western Region reporting unit	$ 558.9	Income Approach	Discount Rate	7.5 % —	7.5%	(7.5%)
Assets held for sale	$ 50.0	Income Approach	Discount Rate	12.0 % —	12.0%	(12.0%)

	Fair Value as of December 31, 2013	Valuation Technique(s)	Unobservable Input	Range (Weighted Average)		
Embedded contractual derivative asset	$ 7.2	Monte Carlo Simulation Approach	Health Net Health Care Expenditures	-3.34 % —	7.34%	(2.20%)
			National Health Care Expenditures	-0.77 % —	9.46%	(3.63%)
Goodwill - Western Region reporting unit	$ 565.9	Income Approach	Discount Rate	10.0 % —	10.0%	(10.0%)
State-sponsored health plans settlement account deficit	$ 62.9	Income Approach	Discount Rate	1.135 % —	1.135%	(1.135%)

Valuation policies and procedures are managed by our finance group, which regularly monitors fair value measurements. Fair value measurements, including those categorized within Level 3, are prepared and reviewed on a quarterly basis and any third-party valuations are reviewed for reasonableness and compliance with the Fair Value Measurement Topic of the Accounting Standards Codification. Specifically, we compare prices received from our pricing service to prices reported by the custodian or third-party investment advisers, and we perform a review of the inputs, validating that they are reasonable and observable in the marketplace, if applicable. For our embedded contractual derivative asset and/or liability, we use internal historical and projected health care expenditure data and the national health care expenditures as reflected in the National External Trend Standards, which is published by CMS, to estimate the unobservable inputs. The growth rates in each of these health care expenditures are modeled using the Monte Carlo simulation approach, and the resulting value is discounted to the valuation date. We estimate our recurring Level 3 state-sponsored health plans settlement account deficit asset using the income approach based on discounted cash flows. We estimate our non-recurring Level 3 asset and goodwill for our Western Region Operations reporting unit using the income approach based on discounted cash flows. We estimate our non-recurring Level 3 assets held for sale based on a combination of the discounted total consideration expected to be received in connection with the services and asset sale agreements, income approach based on a discounted cash flow methodology, and replacement cost methodology.

The significant unobservable inputs used in the fair value measurement of our embedded contractual derivative are the estimated growth in Health Net health care expenditures and the estimated growth in national health care expenditures. Significant increases (decreases) in the estimated growth in Health Net health care expenditures or decreases (increases) in the estimated growth in national health expenditures would result in a significantly lower (higher) fair value measurement. The significant unobservable input used in the fair value measurement of our state-sponsored health plans settlement account deficit asset is our discount rate. Significant increases (decreases) in the discount rate would result in a significantly lower (higher) fair value measurement.

Note 8—Long-Term Equity Compensation

For the year ended December 31, 2014 the compensation cost that has been charged against income under our various stock option and long-term incentive plans ("the Plans") was $28.3 million. The total income tax benefit recognized in the income statement for share-based compensation arrangements was $10.9 million (See Note 2).

Stock options and other equity awards, including but not limited to restricted stock, restricted stock units ("RSUs") and performance share units ("PSUs") have been granted to certain employees, officers and non-employee directors under the Plans. The grant of a single RSU or PSU under our 2006 Long-Term Incentive Plan reduces the number of shares of common stock available for issuance under that plan by 1.75 shares of common stock. RSUs and PSUs granted under that plan prior to May 21, 2009 reduce the number of shares of common stock available for issuance under the 2006 Long-Term Incentive Plan by two shares of common stock for each award. The grant of an option under the 2006 Long-Term Incentive Plan reduces the number of shares of common stock available for issuance under that plan by one share of common stock.

Stock options are granted with an exercise price at or above the fair market value of the Company's common stock on the date of grant. Effective May 21, 2009, stock option grants carry a maximum term of seven years, and, in general, stock options and other equity awards vest based on one to four years of continuous service. Stock option grants made prior to May 21, 2009 carry a maximum term of ten years. As of December 31, 2014, there were no outstanding options or awards that had market or performance condition accelerated vesting provisions. Certain stock options and other equity awards provide for accelerated vesting upon the occurrence of a change in control (as defined in the Plans) under the circumstances set forth in the Plans and equity award agreements. At the end of the maximum term, unexercised stock options are set to expire.

PSUs were granted in 2014. These PSUs have a one-year performance period. Vesting of these PSUs is subject to the recipient's continued employment and these PSUs are earned at 0% or 100% with vesting beginning no earlier than one year after the grant date. The number of shares, if any, to be delivered in connection with these PSUs is dependent upon the Company's satisfaction of certain performance criteria as outlined in each PSU award agreement.

As of December 31, 2014, we have reserved up to an aggregate of 6.5 million shares of our common stock for issuance under the Plans.

The fair value of each option award is estimated on the date of grant using a closed-form option valuation model ("Black-Scholes") based on assumptions, including the risk-free interest rate, expected option term or life, expected volatility, and expected dividend yield, if any. Expected volatilities are based on implied volatilities from traded options on our stock and historical volatility of our stock. We estimated the expected term of options by using historical data to estimate option exercise and employee termination within a lattice-based valuation model. Separate groups of employees that have similar historical exercise behavior are considered separately for valuation purposes. The expected term of options granted is derived from a lattice-based option valuation model and represents the period of time that options granted are expected to be outstanding. The risk-free rate for periods within the contractual life of the option is based on the U.S. Treasury Strip yields in effect at the time of grant with maturity dates approximately equal to the expected life of the option at the grant date.

During the years ended December 31, 2014, 2013 and 2012, we made no grants of stock options. The following table provides the total intrinsic value of options exercised during the years ended December 31:

	2014	2013	2012
Total intrinsic value of options exercised	$ 18,608,206	$ 3,138,634	$ 7,418,459

A summary of option activity under our various plans as of December 31, 2014, and changes during the year then ended is presented below:

	Number of Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2014	3,313,356	$31.33		
Granted	—	—		
Exercised	(1,320,086)	28.52		
Forfeited or expired	(41,059)	42.01		
Outstanding at December 31, 2014	1,952,211	$33.01	2.02	$ 40,278,961
Vested or expected to vest at December 31, 2014 (reflecting estimated forfeiture rates effective in 2014)	1,952,045	$33.01	2.02	$ 40,275,247
Exercisable at December 31, 2014	1,944,500	$33.01	2.01	$ 40,109,115

	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
$15.30 – 20.00	139,100	1.51	$15.41	139,100	$15.41
20.01 – 25.00	555,738	2.18	23.09	555,738	23.09
25.01 – 30.00	136,892	2.88	28.14	135,955	28.14
30.01 – 40.00	519,783	2.26	31.96	513,009	31.96
40.01 – 50.00	479,685	1.37	46.58	479,685	46.58
50.01 – 58.07	121,013	2.40	54.95	121,013	54.95
$15.30 – 58.07	1,952,211	2.02	$33.01	1,944,500	$33.01

We have entered into stock option and RSU agreements with certain employees and non-employee directors and PSU agreements with certain employees. Upon vesting and exercise of each stock option and upon vesting of each RSU and PSU, holders will have the right to receive one share of common stock. Awards of stock options, RSUs and PSUs are subject to restrictions on transfer and forfeiture prior to vesting. The following table presents the number of stock options, RSUs and PSUs granted during the years ended December 31:

	2014	2013	2012
Options granted	—	—	—
RSUs and PSUs granted	881,338	1,143,881	1,084,532

A summary of RSU and PSU activity under our various plans as of December 31, 2014, and changes during the year then ended is presented below:

	Number of Restricted Stock Units and Performance Share Units	Weighted Average Grant-Date Fair Value	Weighted Average Purchase Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2014	1,838,772	$ 29.54	$—		
Granted	881,338	32.25	—		
Vested	(907,072)	29.68	—		
Forfeited	(88,743)	30.21	—		
Outstanding at December 31, 2014	1,724,295	$ 30.82	—	0.87	$ 92,301,511
Expected to vest at December 31, 2014 (reflecting estimated forfeiture rates effective in 2014)	1,649,410	$ 30.84	$—	0.91	$ 88,292,899

The fair values of RSUs and PSUs are determined based on the market value of the underlying shares of common stock on the date of grant.

The weighted-average grant-date fair values and aggregate intrinsic values of RSUs and PSUs vested during the years ended December 31, are as follows:

	2014	2013	2012
Weighted-average grant-date fair values of RSUs and PSUs vested	$ 29.68	$ 29.43	$ 38.22
Aggregate intrinsic value of RSUs and PSUs vested (in millions)	$ 30.5	$ 18.5	$ 49.0

Share-based compensation expense recorded for the years ended December 31, is as follows:

	2014	2013	2012
		(Amounts in millions)	
Compensation expense - options	$ 0.6	$ 3.7	$ 5.4
Compensation expense - RSUs and PSUs	$ 27.7	$ 26.2	$ 23.5

As of December 31, 2014, the remaining unrecognized compensation costs and the respective weighted-average recognition periods are as follows:

	Non-vested Options	Non-vested RSUs & PSUs
Remaining unrecognized compensation cost (in thousands)	$ 28	$ 32,321
Remaining weighted-average period (in years)	0.23	0.93

Under the Plans, employees and non-employee directors may elect for the Company to withhold shares to satisfy minimum statutory federal, state and local tax withholding and/or exercise price obligations, as applicable, arising from the exercise of stock options. For certain other equity awards, the Company has the right to withhold shares to satisfy any tax obligations that may be required to be withheld or paid in connection with such equity award, including any tax obligation arising on the vesting date. During the year ended December 31, 2014, we withheld 0.7 million shares of common stock to satisfy tax withholding and exercise price obligations arising from stock option exercises and the vesting of RSUs and PSUs.

We become entitled to an income tax deduction in an amount equal to the taxable income reported by the holders of the stock options, restricted shares, RSUs and PSUs when vesting occurs, the restrictions are released and the shares are issued. Stock options, restricted common stock, RSUs and PSUs are forfeited if the employees terminate their employment prior to vesting, other than in certain limited situations.

Note 9—Capital Stock

As of December 31, 2014, there were 152,451,000 shares of our common stock issued and 74,378,000 shares of common stock held in treasury, resulting in 78,073,000 shares of our common stock outstanding.

Shareholder Rights Plan

On July 27, 2006, our Board of Directors adopted a shareholder rights plan pursuant to a Rights Agreement with Wells Fargo Bank, N.A. (the "Rights Agent"), dated as of July 27, 2006 (the "Rights Agreement").

In connection with the Rights Agreement, on July 27, 2006, our Board of Directors declared a dividend distribution of one right (a "Right") for each outstanding share of Common Stock to stockholders of record at the close of business on August 7, 2006 (the "Record Date"). Our Board of Directors 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 (as defined below) the redemption of the Rights and the expiration of the Rights and, in certain circumstances, after the Distribution Date. Subject to certain exceptions and adjustment as provided in the Rights Agreement, each Right entitles the registered holder to purchase from us one one-thousandth ($1/1000^{th}$) of a share of Series A Junior Participating Preferred Stock, par value of $0.001 per share, at a purchase price of $170.00 (the "Purchase Price"). The terms of the Rights are set forth in the Rights Agreement.

Rights will attach to all Common Stock certificates representing shares outstanding and no separate certificates evidencing the Rights will be distributed. Subject to certain exceptions contained in the Rights Agreement, the Rights will separate from the Common Stock upon the earliest of (i) 10 days following the public announcement of any person, together with its affiliates and associates (an Acquiring Person), becoming the beneficial owner of 15% or more of the outstanding Common Stock, (ii) 10 business days following 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 Common Stock or (iii) 10 business days following the determination by our Board of Directors that a person, together with its affiliates and associates, has become the beneficial owner of 10% or more of the Common Stock and that such person is an “Adverse Person,” as defined in the Rights Agreement (the earliest of such dates being called the “Distribution Date”). The Rights Agreement provides that certain passive institutional investors that beneficially own less than 20% of the outstanding shares of the Common Stock shall not be deemed to be Acquiring Persons.

The Rights will first become exercisable on the Distribution Date and will expire at the close of business on July 31, 2016 unless such date is extended or the Rights are earlier redeemed or exchanged by us as described below.

Subject to certain exceptions contained in the Rights Agreement, in the event that any person shall become an Acquiring Person or be declared to be an Adverse Person, then the Rights will “flip-in” and entitle each holder of a Right, other than any Acquiring Person or Adverse Person and such person’s affiliates and associates, to purchase, upon exercise at the then-current exercise price of such Right, that number of shares of 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 we are acquired in a merger or other business combination in which the Common Stock does not remain outstanding or is changed or 50% of the assets, cash flow or earning power of the Company is sold or otherwise transferred to any other person, the Rights will “flip-over” and entitle each holder of a Right, other than an Acquiring Person or an Adverse Person and such person’s affiliates and associates, to purchase, upon exercise at the then current exercise price of such Right, such 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.

We may redeem the Rights at a price of $0.01 per Right at any time until the earlier of (i) 10 days following the date that any Acquiring Person becomes the beneficial owner of 15% or more of the outstanding Common Stock and

(ii) the date the Rights expire. In addition, at any time after a person becomes an Acquiring Person or is determined to be an Adverse Person and prior to such person becoming (together with such person's affiliates and associates) the beneficial owner of 50% or more of the outstanding Common Stock, at the election of our Board of Directors, the outstanding Rights (other than those beneficially owned by an Acquiring Person, Adverse Person or an affiliate or associate of an Acquiring Person or Adverse Person) may be exchanged, in whole or in part, for shares of Common Stock, or shares of preferred stock of the Company having essentially the same value or economic rights as such shares.

Stock Repurchase Program

On May 2, 2011, our Board of Directors authorized our stock repurchase program pursuant to which a total of $300 million of our outstanding common stock could be repurchased. On March 8, 2012, our Board of Directors approved a $323.7 million increase to our stock repurchase program and on December 16, 2014, our Board of Directors approved another $257.8 million increase to our stock repurchase program. This latest increase, when taken together with the remaining authorization at that time, brought our total authorization up to $400 million.

Subject to the approval of our Board of Directors, we may repurchase our common stock under our stock repurchase program from time to time in privately negotiated transactions, through accelerated stock repurchase programs or open market transactions, including pursuant to a trading plan in accordance with Rules 10b5-1 and 10b-18 of the Securities Exchange Act of 1934, as amended. The timing of any repurchases and the actual number of shares of stock repurchased will depend on a variety of factors, including the stock price, corporate and regulatory requirements, restrictions under the Company's debt obligations, and other market and economic conditions. Our stock repurchase program may be suspended or discontinued at any time.

During the year ended December 31, 2013, we repurchased 2.7 million shares of our common stock for aggregate consideration of $70.0 million under our stock repurchase program. During the year ended December 31, 2014, we repurchased 3.0 million shares of our common stock for aggregate consideration of $137.8 million under our stock repurchase program. The remaining authorization under our stock repurchase program as of December 31, 2014 was $400.0 million.

Note 10—Employee Benefit Plans

Defined Contribution Retirement Plans

We and certain of our subsidiaries sponsor defined contribution retirement plans intended to qualify under Sections 401(a) and 401(k) of the Internal Revenue Code of 1986, as amended (the "Code"). Certain of the plans were amended and restated effective January 1, 2013 to comply with, among other things, Section 415 of the Code, and certain of the plans were further amended in 2014. Participation in the Company's active plan is available to 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. Our expense under these plans totaled $16.3 million, $16.0 million and $16.4 million for the years ended December 31, 2014, 2013 and 2012, respectively, and is included in general and administrative expense in our consolidated statements of operations.

Deferred Compensation Plans

We have a voluntary deferred compensation plan pursuant to which certain management and highly compensated employees are eligible to defer a certain portion of their regular compensation and bonuses (the "Employee Plan"). In addition, we have a voluntary deferred compensation plan pursuant to which the non-employee members of the Health Net, Inc. Board of Directors are eligible to defer a certain portion of their cash retainers, meeting fees and other cash remuneration (the "BOD Plan"). The compensation deferred under these plans is credited with earnings or losses measured by the mirrored rate of return on investments elected by plan participants. These plans are unfunded. Each plan participant is fully vested in all deferred compensation and earnings credited to his or her account. The BOD Plan was amended and restated effective December 1, 2009 and the Employee Plan was amended and restated effective January 1, 2010. The plans were amended effective November 18, 2013.

As of December 31, 2014 and 2013, the liability under these plans amounted to $50.6 million and $52.0 million, respectively. These liabilities are included in other noncurrent liabilities on our consolidated balance sheets. Deferred compensation expense is recognized for the amount of earnings or losses credited to participant accounts. Our expense under these plans totaled $1.5 million, $2.8 million and $4.2 million for the years ended December 31, 2014, 2013 and 2012, respectively, and is included in general and administrative expense in our consolidated statements of operations.

Pension and Other Postretirement Benefit Plans

Pension Plans—We have an unfunded non-qualified defined benefit pension plan, the Supplemental Executive Retirement Plan. The plan was amended and restated effective January 1, 2008. This plan is noncontributory and covers key executives as selected by our Board of Directors. Benefits under the plan are based on years of service and level of compensation during the final five years of service.

Postretirement Health and Life Plans—Certain of our subsidiaries sponsor postretirement defined benefit health care and life insurance plans that provide postretirement medical and life insurance benefits to directors, key executives, employees and dependents who meet certain eligibility requirements. The Health Net of California Retiree Medical and Life Benefits 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 plan was amended in 2008 to vest benefits for eligible associates who were terminated in connection with the Company’s operations strategy. We have two other benefit plans that we have acquired as part of acquisitions made in 1997. One of the plans is frozen and non-contributory, whereas the other plan is contributory by certain participants. Under these plans, we pay 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 that vary based principally on years of credited service.

The following table sets forth the plans' obligations and funded status at December 31:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
	(Dollars in millions)			
Change in benefit obligation:				
Benefit obligation, beginning of year	$ 40.4	$ 43.4	$ 24.1	$ 26.9
Service cost	1.1	1.2	0.3	0.4
Interest cost	1.8	1.6	1.1	1.0
Change in plan provisions	—	—	—	(0.6)
Benefits paid	(1.2)	(1.2)	(1.1)	(0.9)
Actuarial (gain) loss	7.6	(4.6)	4.4	(2.7)
Benefit obligation, end of year	$ 49.7	$ 40.4	$ 28.8	$ 24.1
Change in fair value of plan assets:				
Plan assets, beginning of year	$ —	$ —	$ —	$ —
Employer contribution	1.2	1.2	1.1	0.9
Benefits paid	(1.2)	(1.2)	(1.1)	(0.9)
Plan assets, end of year	$ —	$ —	$ —	$ —
Underfunded status, end of year	$ (49.7)	$ (40.4)	$ (28.8)	$ (24.1)

HEALTH NET, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Amounts recognized in our consolidated balance sheet as of December 31 consist of:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
	(Dollars in millions)			
Noncurrent assets	$ —	$ —	$ —	$ —
Current liabilities	(1.7)	(1.7)	(0.9)	(1.1)
Noncurrent liabilities	(48.0)	(38.7)	(27.9)	(23.0)
Net amount recognized	$ (49.7)	$ (40.4)	$ (28.8)	$ (24.1)

Amounts recognized in accumulated other comprehensive income as of December 31 consist of:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
	(Dollars in millions)			
Prior service cost	$ —	$ —	$ 0.1	$ 0.3
Net loss (gain)	5.3	0.7	6.1	3.6
	$ 5.3	$ 0.7	$ 6.2	$ 3.9

The following table sets forth our plans with an accumulated benefit obligation in excess of plan assets at December 31:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
	(Dollars in millions)			
Projected benefit obligation	$ 49.7	$ 40.4	$ 28.8	$ 24.1
Accumulated benefit obligation	46.1	37.1	28.8	24.1
Fair value of plan assets	—	—	—	—

Components of net periodic benefit cost recognized in our consolidated statements of operations as general and administrative expense for years ended December 31:

	Pension Benefits			Other Benefits		
	2014	2013	2012	2014	2013	2012
	(Dollars in millions)					
Service cost	$ 1.1	$ 1.2	$ 1.7	$ 0.3	$ 0.4	$ 0.4
Interest cost	1.8	1.6	1.8	1.1	1.0	1.1
Amortization of prior service cost	—	—	—	0.4	0.1	0.1
Amortization of net loss (gain)	—	0.5	1.2	0.2	1.9	2.9
Net periodic benefit cost	$ 2.9	$ 3.3	$ 4.7	$ 2.0	$ 3.4	$ 4.5

The estimated net (gain) loss and prior service cost for the pension and other postretirement benefit plans that will be amortized from accumulated other comprehensive income into net periodic benefit cost over the next fiscal year are $2.2 million and $0.4 million, respectively.

All of our pension and other postretirement benefit plans are unfunded. Employer contributions equal benefits paid during the year. Therefore, no return on assets is expected.

Additional Information

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
Assumptions				
Weighted average assumptions used to determine benefit obligations at December 31:				
Discount rate	3.7%	4.5%	3.9%	4.8%
Rate of compensation increase	6.0%	6.0%	3.5%	3.5%

	Pension Benefits			Other Benefits		
	2014	2013	2012	2014	2013	2012
Weighted average assumptions used to determine net cost for years ended December 31:						
Discount rate	4.5%	3.7%	4.4%	4.8%	4.0%	4.5%
Rate of compensation increase	6.0%	6.0%	5.9%	3.5%	3.5%	3.5%

The discount rates we used to measure our obligations under our pension and other postretirement plans at December 31, 2014 and 2013 mirror the rate of return expected from high-quality fixed income investments.

	2014			2013		
Assumed Health Care Cost Trend Rates at December 31:						
Health care cost trend rates assumed for next year	6.5%	to	12.8%	7.3%	to	16.3%
Rate to which the cost trend rate is assumed to decline (the ultimate trend rate)		5%			5%	
Years that the rate reaches the ultimate trend rate	2024	to	2024	2022	to	2023

Assumed health care cost trend rates have a significant effect on the amounts reported for the health care plans. A one-percentage-point change in assumed health care cost trend rates would have the following effects for the year ended December 31, 2014:

	1-Percentage Point Increase	1-Percentage Point Decrease
	(Dollars in millions)	
Effect on total of service and interest cost	$ 0.2	$ (0.2)
Effect on postretirement benefit obligation	$ 4.7	$ (3.8)

Contributions

We expect to contribute $1.7 million to our pension plan and $0.9 million to our postretirement health and life plans throughout 2015. The entire amount expected to be contributed, in the form of cash, to the defined benefit pension and postretirement health and life plans during 2014 is expected to be paid out as benefits during the same year.

Estimated Future Benefit Payments

We estimate that benefit payments related to our pension and postretirement health and life plans over the next ten years will be as follows:

	Pension Benefits	Other Benefits
	(Dollars in millions)	
2015	$ 1.7	$ 0.9
2016	2.9	1.0
2017	2.9	1.0
2018	2.8	1.1
2019	2.8	1.1
Years 2019—2024	16.7	6.7

Note 11—Income Taxes

Continuing Operations

Significant components of the provision for income taxes from continuing operations are as follows for the years ended December 31:

	2014	2013	2012
	(Dollars in millions)		
Current tax expense:			
Federal	$ 87.7	$ 79.0	$ (3.4)
State	(15.0)	12.5	(1.2)
Total current tax expense	72.7	91.5	(4.6)
Deferred tax expense (benefit):			
Federal	2.4	15.0	11.1
State	(19.0)	(6.4)	(2.2)
Total deferred tax expense (benefit)	(16.6)	8.6	8.9
Interest expense, gross of related tax effects	(1.9)	(0.3)	1.7
Total income tax provision	$ 54.2	$ 99.8	$ 6.0

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:

	2014	2013	2012
Statutory federal income tax rate	35.0%	35.0%	35.0%
State and local taxes, net of federal income tax effect	(11.1)	1.5	(6.9)
Valuation allowance (release) against capital losses, net operating losses or tax credits	—	—	(26.5)
Loss on subsidiary stock	(24.9)	—	—
Non-deductible health insurer fee	24.8	—	—
Non-deductible compensation	4.8	3.6	17.7
Tax exempt interest income	(2.9)	(2.4)	(12.7)
Sale of subsidiaries	—	—	1.8
Interest expense	(1.0)	(0.1)	5.3
Lobbying expense	0.6	0.4	3.4
Other, net	1.8	(1.0)	1.8
Effective income tax rate	27.1%	37.0%	18.9%

The effective income tax rate from continuing operations was 27.1%, 37.0% and 18.9% for the years ended December 31, 2014, 2013 and 2012, respectively. For the year ended December 31, 2014, our effective tax rate was impacted by the health insurer fee which became effective under the ACA. Our health insurance industry fee payment of $141.4 million in 2014 was not deductible for federal income tax purposes and in many state jurisdictions. See Note 2, under the heading "Accounting for Certain Provisions of the ACA—Premium-based Fee on Health Insurers" for additional information regarding the health insurance industry fee.

During the year ended December 31, 2014, we recorded a $73.7 million tax benefit, net of adjustments to our reserve for uncertain tax benefits, as a result of a worthless stock loss. The loss was incurred with respect to the stock of Health Net of the Northeast, Inc., the former parent company of subsidiaries sold to an affiliate of UnitedHealth Group in 2009. The amount and character of the loss could be challenged by the taxing authorities, and as such, we increased our reserve for uncertain tax positions by $16.4 million related to this transaction. The tax benefit from the stock loss was primarily responsible for reducing our statutory tax rate below the statutory federal tax rate of 35% for the year ended December 31, 2014.

In all periods presented, our effective income tax rate has not been impacted by operations in foreign jurisdictions with varying statutory tax rates. Our health care operations are almost entirely domestic.

Significant components of our deferred tax assets and liabilities as of December 31 are as follows:

	2014	2013
	(Dollars in millions)	
DEFERRED TAX ASSETS:		
Accrued liabilities	$ 72.8	$ 87.8
Accrued compensation and benefits	68.8	67.1
Net operating and capital loss carryforwards	21.6	22.2
Unrealized losses on investments	0.5	16.7
Insurance loss reserves and unearned premiums	13.7	12.7
Deferred gain and revenues	1.3	6.6
Tax credits	10.8	8.8
Deferred tax assets before valuation allowance	189.5	221.9
Valuation allowance	(13.3)	(23.3)
Net deferred tax assets	$ 176.2	$ 198.6
DEFERRED TAX LIABILITIES:		
Depreciable and amortizable property	$ 53.0	$ 77.1
Prepaid expenses	10.7	14.9
Deferred revenue	9.6	13.2
Unrealized gains on investments	5.6	—
Other	6.3	4.0
Deferred tax liabilities	$ 85.2	$ 109.2

During 2014, our total valuation allowance decreased by a net $10 million, primarily resulting from the expiration of a $6 million state capital loss carryforward upon which the valuation allowance was based.

For 2014, 2013 and 2012 the income tax benefit realized from share-based award exercises was $8.7 million, $6.1 million and $16.6 million, respectively. Of the tax benefits realized, $1.1 million, $(1.4) million and $5.1 million were allocated to stockholders' equity in 2014, 2013 and 2012, respectively.

As of December 31, 2014, we had federal and state net operating loss carryforwards of approximately $6.1 million and $270.6 million, respectively. The net operating loss carryforwards expire at various dates through 2034.

Limitations on utilization may apply to all of the federal and state net operating loss carryforwards. Accordingly, valuation allowances have been provided to account for the potential limitations on utilization of these tax benefits. No portion of the 2014 valuation allowance was allocated to reduce goodwill.

We maintain a liability for unrecognized tax benefits that includes the estimated amount of contingent adjustments that may be sustained by taxing authorities upon examination. A reconciliation of the beginning and ending amount of unrecognized tax benefits, exclusive of related interest, is as follows:

	2014	2013	2012
	(Dollars in millions)		
Gross unrecognized tax benefits at beginning of year	$ 55.6	$ 57.3	$ 47.1
Increases in unrecognized tax benefits related to the current year	25.5	4.4	2.4
Increases in unrecognized tax benefits related to prior years	—	—	8.0
Decreases in unrecognized tax benefits related to a prior year	(17.5)	(0.2)	(0.2)
Settlements with taxing authorities	—	(1.9)	—
Lapse in statute of limitation for assessment	(2.1)	(4.0)	—
Gross unrecognized tax benefits at end of year	$ 61.5	$ 55.6	$ 57.3

Of the $64.9 million total liability at December 31, 2014 for unrecognized tax benefits, including interest and penalties, approximately $19.6 million would, if recognized, impact the Company's effective tax rate. The remaining $45.3 million would impact deferred tax assets. Of the $59.3 million total liability at December 31, 2013 for unrecognized tax benefits, including interest and penalties, approximately $9.7 million would, if recognized, impact the Company's effective tax rate. The remaining $49.6 million would impact deferred tax assets.

We recognized interest and any applicable penalties which could be assessed related to unrecognized tax benefits in income tax provision expense. Accrued interest and penalties are included within the related tax liability in the consolidated balance sheet. During 2014, 2013 and 2012, ($1.9) million, ($0.3) million and $1.7 million, respectively, of interest was recorded as income tax (benefit) provision. We reported interest accruals of $1.8 million, $3.7 million and $4.1 million at December 31, 2014, 2013 and 2012, respectively. Provision expense and accruals for penalties were immaterial in all reporting periods.

We file tax returns in the federal as well as several state tax jurisdictions. As of December 31, 2014, tax years subject to examination in the federal jurisdiction are 2010 and forward. The most significant state tax jurisdiction for us is California, and tax years subject to examination by that jurisdiction are 2010 and forward. Presently we are under examination by various state taxing authorities. We do not believe that any ongoing examination will have a material impact on our consolidated balance sheet and results of operations.

In the next twelve months, it is reasonably possible that our unrecognized tax benefits could decrease by up to $7.2 million due to examination settlements or alternatively increase by up to $2.6 million assuming we are able to utilize certain net operating loss and tax credit carryforwards that are currently subject to uncertainty.

Discontinued Operation

On April 1, 2012, we completed the sale of our Medicare PDP business to CVS Caremark. For the year ended December 31, 2012, we recorded tax expense of $18.0 million net against the gain on sale of discontinued operation. See Note 3 for additional information regarding the sale of our Medicare PDP business. The effective tax rate differs from the federal statutory rate of 35% due primarily to the impact of non-deductible goodwill impairment and a reduction in the valuation allowance against deferred tax assets, which resulted from the utilization of capital loss carryforwards against the gain on the sale of our Medicare PDP business.

As a result of the sale, the operating results of our Medicare PDP business have been classified as discontinued operation in our consolidated statements of operations for the year ended December 31, 2012. We recorded a tax benefit of $10.3 million net against the loss from discontinued operation for the year ended December 31, 2012. The effective income tax rates related to income or loss from discontinued operation remained relatively constant throughout 2012 at slightly above the federal statutory tax rate of 35% due to state income taxes. We had no income or loss and no tax expense or benefit for discontinued operation for the years ended December 31, 2013 and 2014.

Note 12—Regulatory Requirements

All of our health plans as well as our insurance subsidiaries ("regulated subsidiaries") are required to maintain minimum capital standards and certain restricted accounts or assets, in accordance with legal and regulatory requirements. For example, under the Knox-Keene Health Care Service Plan Act of 1975, as amended, our California health plans are regulated by the California Department of Managed Health Care ("DMHC") and must comply with certain minimum capital or tangible net equity requirements. Our non-California health plans as well as our insurance subsidiaries must comply with their respective state's minimum regulatory capital requirements. As necessary, we make contributions to and issue standby letters of credit on behalf of our regulated subsidiaries to meet risk based capital ("RBC") or other statutory capital requirements under various state laws and regulations, and to meet the capital standards of credit rating agencies. In addition, in California and in certain other jurisdictions, our regulated subsidiaries are required to maintain minimum investment amounts for the restricted use of the regulators in certain limited circumstances. See the “Restricted Assets” section in Note 2 for additional information.

Certain of our subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, or statutory accounting. These subsidiaries are domiciled in various jurisdictions and prepare statutory financial statements in accordance with accounting practices prescribed or permitted by the respective jurisdictions' insurance regulators. Prescribed statutory accounting practices are set forth in a variety of publications of the National Association of Insurance Commissioners ("NAIC") as well as state laws, regulations and general administrative rules. The NAIC has developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting.

Statutory reporting varies in certain respects from GAAP. Typical differences of statutory reporting as compared to GAAP reporting are the reporting of fixed maturity securities at amortized cost, not recognizing certain assets including those that are non-admitted for statutory purposes and certain reporting classifications. Statutory-basis capital and surplus of our health plan subsidiaries was $188.5 million and $138.6 million at December 31, 2014 and 2013, respectively. Statutory-basis net (loss) income of our health plan subsidiaries was approximately $(130.5) million, $(158,000) and $44,000 for the years ended December 31, 2014, 2013 and 2012, respectively.

Our subsidiaries that are regulated by DMHC report their accounts in conformity with GAAP. GAAP equity of our DMHC regulated subsidiaries was $1.3 billion and $1.2 billion at December 31, 2014 and 2013, respectively. GAAP net income of our DMHC regulated subsidiaries was $202.3 million, $140.7 million and $122.1 million for the years ended December 31, 2014, 2013 and 2012, respectively. We are a holding company and, therefore, our ability to pay dividends depends on distributions received from our subsidiaries, which are subject to regulatory capital requirements and other requirements of state law and regulation. As a result of these regulatory capital requirements and other requirements of state law and regulation, certain regulated subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to us, or their ability to do so is conditioned upon prior regulatory approval or non-objection. Such restrictions, unless amended or waived, limit the use of any cash generated by these subsidiaries to pay our obligations or make dividends. The maximum amount of dividends that can be paid by the regulated subsidiaries to us without prior approval of the state regulatory authorities is subject to restrictions relating to statutory surplus, statutory income and tangible net equity. See Note 6 for further discussion of restrictions on our ability to pay dividends to our stockholders that are contained in our revolving credit facility.

Based on operations as of December 31, 2014, the amount of statutory capital and surplus or net worth of our regulated subsidiaries necessary to satisfy regulatory requirements was $487.0 million in the aggregate. As of December 31, 2014, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was approximately $487.0 million in the aggregate. As of December 31, 2014, the amount of restricted net assets of our regulated subsidiaries was approximately $119.2 million in the aggregate. Management believes that as of December 31, 2014 all of our active regulated subsidiaries met their respective regulatory requirements relating to maintenance of minimum capital standards and restricted accounts or assets in all material respects.

Note 13—Commitments and Contingencies

Legal Proceedings

Overview

We record reserves and accrue costs for certain legal proceedings and regulatory matters to the extent that we determine an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect our best estimate of the probable loss for such matters, our recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to that they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings, each with a wide range of potential outcomes; or result in a change of business practices. Further, there may be various levels of judicial review available to the Company in connection with any such proceeding in the event damages are awarded or a fine or penalty is assessed. As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period our financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including those described below in this Note 13 under the heading "Military and Family Life Counseling Program Putative Class and Collective Actions," depending, in part, upon our financial condition, results of operations, cash flow or liquidity in such period, and our reputation may be adversely affected. Except for the regulatory and legal proceedings discussed in this Note 13 under the heading "Military and Family Life Counseling Program Putative Class and Collective Actions," management believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against us should not have a material adverse effect on our financial condition, results of operations, cash flow and liquidity.

Military and Family Life Counseling Program Putative Class and Collective Actions

We are a defendant in three related litigation matters pending in the United States District Court for the Northern District of California (the "Northern District of California") relating to the independent contractor classification of counselors ("MFLCs") who contracted with our subsidiary, MHN Government Services, Inc. ("MHNGS"), to provide short-term, non-medical counseling at U.S. military installations throughout the country under our Military and Family Life Counseling (formerly Military and Family Life Consultants) program.

On June 14, 2011, two former MFLCs filed a putative class action in the Superior Court of the State of Washington for Pierce County against Health Net, Inc., MHNGS, and MHN Services d/b/a MHN Services Corporation (also a subsidiary), on behalf of themselves and a proposed class of current and former MFLCs who have performed services as independent contractors in the state of Washington from June 14, 2008 to the present. Plaintiffs claim that MFLCs were misclassified as independent contractors under Washington law and are entitled to the wages and overtime pay that they would have received had they been classified as non-exempt employees. Plaintiffs seek unpaid wages, overtime pay, statutory penalties, attorneys' fees and interest. We moved to compel the case to arbitration, and the court denied the motion on September 30, 2011. We appealed the decision. The Washington Supreme Court affirmed the trial court's decision on August 15, 2013. On February 26, 2014, we removed this case to the United States District Court for the Western District of Washington, pursuant to the Class Action Fairness Act.

On May 15, 2012, the same two MFLCs who filed the Washington action, as well as 12 other named plaintiffs, filed a proposed collective action lawsuit against the same defendants in the United States District Court for the Western District of Washington on behalf of themselves and other current and former MFLCs who have performed services as independent contractors nationwide from May 15, 2009 to the present. They allege misclassification under the federal Fair Labor Standards Act ("FLSA") and seek unpaid wages, unpaid benefits, overtime pay, statutory penalties, attorneys' fees and interest. They also seek penalties under California Labor Code section 226.8. The court has since transferred the case to the Northern District of California to relate it to a virtually identical suit filed on October 2, 2012 against MHNGS and Managed Health Network, Inc. ("MHN") (also a subsidiary).

The third October 2012 suit alleges misclassification under the FLSA on behalf of a nationwide class, as well under several state laws on behalf of MFLCs who worked in California, New Mexico, Hawaii, Kentucky, New York, Nevada, and North Carolina. On October 24, 2013, the parties agreed to toll the statutes of limitations for overtime violations in the following states: Alaska, Colorado, Illinois, Maine, Maryland, Massachusetts, Montana, New Jersey, North Dakota, Ohio, and Pennsylvania.

On November 1, 2012, we moved to compel arbitration in the Northern District of California, and the court denied the motion on April 3, 2013. We noticed our appeal of that decision to the United States Court of Appeals for the Ninth Circuit on April 8, 2013. On April 25, 2013, the district court granted Plaintiffs' motion for conditional FLSA collective action certification to allow notice to be sent to the FLSA collective action members. The court stayed all other proceedings pending an outcome in the Ninth Circuit appeal. On December 17, 2014, a divided (2-1) Ninth Circuit panel affirmed the district court's decision denying our motion to compel arbitration. On January 14, 2015, we petitioned for rehearing en banc, and the Ninth Circuit denied the petition on February 9, 2015. On February 13, 2015, the Ninth Circuit granted our motion to stay the proceedings, and the proceedings will remain stayed until the final disposition by the U.S. Supreme Court of our petition for a writ of certiorari.

On March 28, 2014, the original Washington case was transferred to the Northern District of California to relate it to the two FLSA suits pending there. On April 11, 2014, we moved to stay the suit pending the Ninth Circuit appeal. We also filed two alternative motions seeking an order to either compel the case to arbitration or dismiss Plaintiffs' class claims and California Labor Code section 226.8 claims. On June 3, 2014, the court granted our motion to stay, and denied the later alternative motions without prejudice to renewal after the stay is lifted.

We intend to vigorously defend ourselves against these claims; however, these proceedings are subject to many uncertainties.

Miscellaneous Proceedings

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

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

We intend to vigorously defend ourselves against the miscellaneous legal and regulatory proceedings to which we are currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against us, substantial non-economic or punitive damages are being sought.

Potential Settlements

We regularly evaluate legal proceedings and regulatory matters pending against us, including those described above in this Note 13, to determine if settlement of such matters would be in the best interests of the Company and its stockholders. The costs associated with any settlement of the various legal proceedings and regulatory matters to which we are or may be subject from time to time, including those described above in this Note 13, could be substantial and, in certain cases, could result in a significant earnings charge or impact on our cash flow in any particular quarter in which we enter into a settlement agreement and could have a material adverse effect on our financial condition, results of operations, cash flow and/or liquidity and may affect our reputation.

Operating Leases and Long-Term Purchase Obligations

Operating Leases

We lease administrative office space throughout the country under various operating leases. Certain leases contain renewal options and rent escalation clauses. Certain leases are cancelable with substantial penalties.

We lease office space in multiple locations in Shelton, Connecticut under operating lease agreements for remaining terms ranging from two to three years. We began monitoring these leases for impairment after the Northeast Sale in December 2009 although we remained in these sites to conduct related transition work. In December 2012 after vacating these sites, we recorded a lease impairment totaling $7.4 million in our divested operations and services expenses. The lease impairment amount represented the fair value of future lease obligations discounted using a credit adjusted risk-free interest rate of 3.26%.

We lease an office space in Woodland Hills, California that is used for operations in our Western Region Operations and Government Contracts reportable segments under an operating lease agreement. In 2014, we extended the lease agreement through December 31, 2017 and it does not provide for complete cancellation rights. As of December 31, 2014, the total future minimum lease commitments under the lease were approximately $8.8 million.

We lease an office space in Woodland Hills, California for our California health plan under an operating lease agreement. The lease expires on December 31, 2021 and it contains provisions for full or partial termination under certain circumstances with substantial consideration payable to the landlord. As of December 31, 2014, the total future minimum lease commitments under this lease were approximately $83.9 million.

Long-Term Purchase Obligations

We have entered into long-term agreements to purchase various services, which may contain certain termination provisions and have remaining terms in excess of one year as of December 31, 2014.

We have entered into long-term agreements to receive services related to disease management, case management, wellness, pharmacy benefit management, pharmacy claims processing services and health quality/risk scoring enhancement services with external third-party service providers. As of December 31, 2014, the remaining terms were approximately from one to two years for these contracts, and termination of these agreements is subject to certain termination provisions. As of December 31, 2014, the total estimated future commitments under these agreements were $122.1 million.

We have entered into an agreement with International Business Machines Corporation ("IBM") to outsource our IT infrastructure management services including data center services, IT security management and help desk support. In 2014, we extended the agreement, and as of December 31, 2014, the remaining term of this contract was approximately one year, and the total estimated future commitments under the agreement were approximately $101.2 million.

We have entered into an agreement with Cognizant Technology Solutions U.S. Corporation ("Cognizant") to outsource our software applications development and management activities to Cognizant. Under the terms of the agreement, Cognizant, among other things, provides us with services including the following: application development, testing and monitoring services, application maintenance and support services, project management services and cross functional services. In 2014, we extended the agreement, and as of December 31, 2014, the remaining term of this contract was approximately four years, and the total estimated future commitments under the agreement were approximately $288.1 million.

We have also entered into another agreement with Cognizant to outsource a substantial portion of our claims processing activities to Cognizant. Under the terms of the agreement, Cognizant, among other things, provides us with claims adjudication, adjustment, audit and process improvement services. As of December 31, 2014, the remaining term of this contract was approximately two years, and the total estimated future commitments under the agreement were approximately $25.4 million.

We have also entered into contracts with our health care providers and facilities, the federal government, other IT service companies and other parties within the normal course of our business for the purpose of providing health care services. Certain of these contracts are cancelable with substantial penalties.

As of December 31, 2014, future minimum commitments for operating leases and long-term purchase obligations for the years ending December 31 are as follows:

	Operating Leases	Long-Term Purchase Obligations
	(Dollars in millions)	
2015	$ 55.5	$ 314.4
2016	49.8	244.1
2017	38.2	110.8
2018	26.1	77.6
2019	21.3	—
Thereafter	46.5	—
Total minimum commitments	$ 237.4	$ 746.9

Lease expense totaled $44.8 million, $45.1 million and $47.8 million for the years ended December 31, 2014, 2013 and 2012, respectively. Long-term purchase obligation expenses totaled $250.2 million, $217.2 million and $214.9 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Surety Bonds

Under our Arizona Medicaid contract with the AHCCCS, we are required to provide a financial guarantee for the payment of claims. We have elected to satisfy the financial guarantee by purchasing a performance bond. The bond requirement is based on the expected monthly capitation to be received from the state of Arizona. The estimated calculation is based on historical capitation rates applied to forecasted membership and adjusted on an as needed basis during the year. As of December 31, 2014, the performance bond amount was $24 million. It was increased to $28 million effective January 1, 2015.

Under this performance bond if we were to fail to pay claims, the issuers of the performance bond would make payments in an amount required by the AHCCCS up to the bond amount. We would, in turn, be responsible for reimbursing the issuing insurance carrier for any payments it made on our behalf. To the extent the Company incurs liabilities as a result of the arrangements under the performance bond, such liabilities would be included on the Company's consolidated balance sheet.

At this time, we do not believe we will be required to fund or draw down any amounts related to the performance bond. Accordingly, no liability related to the performance bond has been recognized in the Company's financial statements as of December 31, 2014.

Note 14—Segment Information

Our reportable segments are comprised of Western Region Operations and Government Contracts. Effective January 1, 2013, we closed out our Divested Operations and Services segment as discussed below. Our Western Region Operations reportable segment includes the operations of our commercial, Medicare, Medicaid and dual eligibles health plans, our health and life insurance companies, our pharmaceutical services subsidiaries and certain operations of our behavioral health subsidiaries. These operations are conducted primarily in California, Arizona, Oregon and Washington. As a result of the classification of our Medicare PDP business as discontinued operations, our Western Region Operations reportable segment excludes the operating results of our Medicare PDP business for the year ended December 31, 2012. Our Government Contracts reportable segment includes government-sponsored managed care and administrative services contracts through the TRICARE program, the Department of Defense MFLC program, the VA's PC3 Program and certain other health care-related government contracts. For the year ended December 31, 2012, our Divested Operations and Services reportable segment included the run-out of our Northeast business that was sold in the Northeast Sale on December 11, 2009 and transition-related revenues and expenses of our Medicare PDP business that was sold on April 1, 2012. As of December 31, 2012, we had substantially completed the administration and run-out of our divested businesses. See Note 3 for more information regarding the sale of our Medicare PDP business and the Northeast Sale. In connection with the Cognizant Transaction, we reviewed our reportable segments and determined that no changes to our reportable segments were necessary. See Note 3 for additional information regarding the Cognizant Transaction.

The financial results of our reportable segments are reviewed on a monthly basis by our chief operating decision maker ("CODM"). We continuously monitor our reportable segments to ensure that they reflect how our CODM manages our company.

We evaluate performance and allocate resources based on segment pretax income. Our assets are managed centrally and viewed by our CODM on consolidated basis; therefore, they are not allocated to our segments and our segments are not evaluated for performance based on assets. The accounting policies of the reportable segments are the same as those described in the summary of significant accounting policies (see Note 2), except that intersegment transactions are not eliminated. We include investment income, administrative services fees and other income and expenses associated with our corporate shared services and other costs in determining our Western Region Operations and Divested Operations and Services reportable segments' pretax income to reflect the fact that these revenues and expenses are primarily used to support our Western Region Operations and Divested Operations and Services.

We also have a Corporate/Other segment that is not a business operating segment. It is added to our reportable segments to provide a reconciliation to our consolidated results. The Corporate/Other segment includes costs that are excluded from the calculation of segment pretax income because they are not managed within the segments and are not directly identified with a particular operating segment. Accordingly, these costs are not included in the performance evaluation of our reportable segments by our CODM. In addition, certain charges, including but not limited to those related to our continuing efforts to address scale issues, as well as asset impairments, are reported as part of Corporate/Other.

HEALTH NET, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Presented below are segment data for the three years ended December 31, 2014, 2013 and 2012.

2014

	Western Region Operations	Government Contracts	Corporate/Other/ Eliminations	Total
	(Dollars in millions)			
Revenues from external sources	$ 13,361.2	$ 604.0	$ —	$ 13,965.2
Intersegment revenues	12.4	—	(12.4)	—
Net investment income	45.2	—	—	45.2
Administrative services fees and other income	(1.7)	—	—	(1.7)
Interest expense	31.4	—	—	31.4
Depreciation and amortization	29.7	—	0.1	29.8
Share-based compensation expense	25.0	3.3	—	28.3
Segment pretax income (loss)	315.6	69.5	(185.3)	199.8

2013

	Western Region Operations	Government Contracts	Corporate/Other/ Eliminations	Total
	(Dollars in millions)			
Revenues from external sources	$ 10,377.1	$ 572.3	$ —	$ 10,949.4
Intersegment revenues	11.1	—	(11.1)	—
Net investment income	69.6	—	—	69.6
Administrative services fees and other income	34.8	—	—	34.8
Interest expense	32.6	—	—	32.6
Depreciation and amortization	38.6	—	—	38.6
Share-based compensation expense	26.1	3.8	—	29.9
Segment pretax income (loss)	207.5	74.5	(12.0)	270.0

2012

	Western Region Operations	Government Contracts	Divested Operations and Services	Corporate/Other/ Eliminations	Total
			(Dollars in millions)		
Revenues from external sources	$ 10,459.1	$ 689.1	$ —	$ —	$ 11,148.2
Intersegment revenues	11.0	—	—	(11.0)	—
Net investment income	82.4	—	—	—	82.4
Administrative services fees and other income	18.0	—	—	—	18.0
Divested operations and services revenue	—	—	40.5	—	40.5
Interest expense	33.2	—	—	—	33.2
Depreciation and amortization	31.1	—	—	—	31.1
Share-based compensation expense	24.1	4.2	0.6	—	28.9
Segment pretax income (loss)	29.2	89.9	(45.4)	(42.0)	31.7

Our health plan services premium revenue by line of business is as follows:

	Year Ended December 31,		
	2014	2013	2012
	(Dollars in millions)		
Commercial premium revenue	$ 5,443.1	$ 5,175.4	5,705.5
Medicare premium revenue	3,044.3	2,771.4	2,790.5
Medicaid premium revenue	4,755.9	2,430.3	1,963.1
Dual Eligibles premium revenue	117.9	—	—
Total health plan services premiums	$ 13,361.2	$ 10,377.1	$ 10,459.1

Note 15—Reserves for Claims and Other Settlements

Reserves for claims and other settlements include reserves for claims (IBNR claims and received but unprocessed claims), and other liabilities including capitation payable, shared risk settlements, provider disputes, provider incentives and other reserves for our health plan services. The table below provides a reconciliation of changes in reserve for claims for the years ended December 31, 2014, 2013 and 2012.

	Health Plan Services Year Ended December 31,		
	2014	2013	2012
	(Dollars in millions)		
Reserve for claims (a), beginning of period	$ 807.4	$ 808.7	$ 720.8
Incurred claims related to:			
Current year (f)	5,613.0	4,666.0	4,950.9
Prior years (c)	(14.6)	(56.2)	34.5
Total incurred (b)	5,598.4	4,609.8	4,985.4
Paid claims related to:			
Current year	4,443.2	3,872.5	4,156.6
Prior years	776.3	738.6	740.9
Total paid (b)	5,219.5	4,611.1	4,897.5
Reserve for claims (a), end of period	1,186.3	807.4	808.7
Add:			
Claims and claims-related payable (d)	175.4	67.0	91.6
Other (e)	534.3	109.7	137.7
Reserves for claims and other settlements, end of period	$ 1,896.0	$ 984.1	$ 1,038.0

____

(a) Consists of IBNR claims and received but unprocessed claims and reserves for loss adjustment expenses.

(b) Includes medical claims only. Capitation, pharmacy and other payments (including, for example, provider settlements) are not included.

(c) This line represents the change in reserves attributable to the difference between the original estimate of incurred claims for prior years and the revised estimate. Negative amounts in this line represent favorable development in estimated prior years’ health care costs. Positive amounts in this line represent unfavorable development in estimated prior years’ health care costs. The net favorable development related to prior years that was recorded in the year ended December 31, 2014 consisted of $36.6 million in unfavorable prior year development primarily due to unanticipated benefit utilization in our commercial business arising from dates of service in the fourth quarter of 2013 as a result of an uncertain environment related to the ACA and a release of $51.2 million of the provision for adverse deviation held at December 31, 2013. The favorable development related to prior years that was recorded in the year ended December 31, 2013 resulted from claims being settled for amounts less than originally estimated. In 2013, this was primarily due to the absence of moderately adverse conditions. The favorable developments related to prior years that were recorded in 2014 and 2013 do not directly correspond to an increase in our operating results for those periods because any favorable prior period reserve development increases current period net income only to the extent that the current period provision for adverse deviation (see footnote (f)) is less than the benefit recognized from the prior period favorable development. The unfavorable development in estimated prior years' health care costs for 2012 primarily resulted from significant delays in claims submissions for the fourth quarter of 2011 arising from issues related to a new billing format required by HIPAA combined with an unanticipated flattening of commercial trends. See Note 2 under the heading "Health Plan Services Health Care Cost" for more information.

(d) Includes claims payable, provider dispute reserve, and other claims-related liabilities.

(e) Includes accrued capitation, shared risk settlements, provider incentives and other reserve items.

(f) Our IBNR estimate also includes a provision for adverse deviation, which is an estimate for known environmental factors that are reasonably likely to affect the required level of IBNR reserves. Such amounts were $77.7 million,

$53.4 million and $53.4 million as of December 31, 2014, 2013 and 2012, respectively; the increase in the provision for adverse deviation from December 31, 2013 to December 31, 2014 was primarily driven by growth in our new products offered or programs administered under the ACA.

The following table shows the Company's health plan services expenses for the years ended December 31:

	Health Plan Services		
	2014	2013	2012
	(Dollars in millions)		
Total incurred fee for service claims	$ 5,598.4	$ 4,609.8	$ 4,985.4
Capitated expenses and shared risk	4,256.8	3,108.0	3,128.1
Pharmacy and other	1,452.6	1,168.7	1,202.8
Health plan services	$ 11,307.8	$ 8,886.5	$ 9,316.3

For the years ended December 31, 2014, 2013 and 2012, the Company's capitated, shared risk, pharmacy and other expenses represented 50%, 48% and 46%, respectively, of the Company's total health plan services.

Note 16—Quarterly Information (Unaudited)

The following interim financial information presents the 2014 and 2013 results of operations on a quarterly basis:

2014

	March 31	June 30	September 30	December 31
	(Dollars in millions, except per share data)			
Total revenues	$ 3,038.9	$ 3,421.4	$ 3,789.9	$ 3,758.4
Health plan services costs	2,402.3	2,763.2	3,104.0	3,038.2
Government contracts costs	132.0	133.2	124.4	147.1
Income from continuing operations before income taxes	62.0 (1)	98.8 (2)	22.7 (4) (5)	16.3 (6) (7)
Net income (loss)	28.8 (1)	120.9 (2) (3)	(8.9) (4) (5)	4.9 (6) (7)
Basic earnings (loss) per share	$ 0.36	$ 1.51	$ (0.11)	$ 0.06
Diluted earnings (loss) per share (8)	$ 0.36	$ 1.49	$ (0.11)	$ 0.06

____

(1) Includes $36.3 million amortization of deferred costs of health insurer's fee and $22.5 million in other ACA fees.
(2) Includes $37.8 million amortization of deferred costs of health insurer's fee and $22.5 million in other ACA fees.
(3) Includes tax benefit of $72.6 million, net of adjustments, as a result of a loss on the stock of one of our subsidiaries.
(4) Includes $84.7 million pretax asset impairment related to our assets held for sale in connection with the Cognizant Transaction and $21.1 million in pretax expenses primarily related to the Cognizant transaction.
(5) Includes $31.9 million amortization of deferred costs of health insurer's fee and $26.6 million in other ACA fees.
(6) Includes $3.8 million pretax asset impairment primarily related to our assets held for sale in connection with the Cognizant Transaction and $68.3 million in pretax expenses primarily related to the Cognizant Transaction.
(7) Includes $35.4 million amortization of deferred costs of health insurer's fee and $25.8 million in other ACA fees.
(8) The sum of the quarterly amounts may not equal the year-to-date amounts due to rounding.

2013

	March 31	June 30	September 30	December 31
	(Dollars in millions, except per share data)			
Total revenues	$ 2,797.0	$ 2,738.4	$ 2,775.0	$ 2,743.2
Health plan services costs	2,268.7	2,191.9	2,196.6	2,229.3
Government contracts costs	125.5	127.4	125.3	124.7
Income from continuing operations before income taxes	81.3	52.0	108.6	28.0
Net income	50.1 (1)	33.5 (2)	66.8 (3)	19.8
Basic earnings per share	$ 0.63	$ 0.42	$ 0.84	$ 0.25
Diluted earnings per share (4)	$ 0.62	$ 0.42	$ 0.83	$ 0.25

____
(1) Includes $42.2 million of Medicaid premium revenue as a result of Medicaid/Medi-Cal retroactive rate adjustments related to 2011 and 2012.
(2) Includes a $12.9 million in pretax costs related to continuing efforts to address scale issues.
(3) Includes $32.1 million of Medicaid premium revenue as a result of Medicaid/Medi-Cal retroactive rate adjustments for periods prior to 2013.
(4) The sum of the quarterly amounts may not equal the year-to-date amounts due to rounding.

SUPPLEMENTAL SCHEDULE I

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)

HEALTH NET, INC.

CONDENSED STATEMENTS OF OPERATIONS
(Amounts in thousands)

	Year Ended December 31,		
	2014	**2013**	**2012**
REVENUES:			
Net investment (loss) income	$ (125)	$ 1,316	$ 1,459
Other income	8	229	204
Administrative service fees	477,440	464,393	478,037
Total revenues	477,323	465,938	479,700
EXPENSES:			
General and administrative	524,751	431,354	470,156
Depreciation and amortization	28,207	36,185	30,408
Interest	31,376	33,589	35,112
Asset Impairment	88,528	—	—
Total expenses	672,862	501,128	535,676
Loss from operations before income taxes and equity in net income of subsidiaries	(195,539)	(35,190)	(55,976)
Income tax benefit	53,011	13,014	5,633
Equity in net income (loss) of subsidiaries	288,157	192,302	172,406
Net income	$ 145,629	$ 170,126	$ 122,063

See accompanying notes to condensed financial statements.

SUPPLEMENTAL SCHEDULE I

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)

HEALTH NET, INC.

CONDENSED STATEMENTS OF COMPREHENSIVE INCOME
(Amounts in thousands)

	Year Ended December 31,		
	2014	2013	2012
Net income	$ 145,629	$ 170,126	$ 122,063
Other comprehensive income before tax:			
Unrealized gains (losses) on investments available-for-sale:			
Unrealized holding gains (losses) arising during the period	59,073	(78,217)	65,462
Less: Reclassification adjustments for gains included in earnings	(2,710)	(23,975)	(36,680)
Unrealized gains (losses) on investments available-for-sale, net	56,363	(102,192)	28,782
Defined benefit pension plans:			
Prior service cost arising during the period	—	607	—
Net (loss) gain arising during the period	(11,893)	7,294	(646)
Less: Amortization of prior service cost and net loss included in net periodic pension cost	600	2,572	4,152
Defined benefit pension plans, net	(11,293)	10,473	3,506
Other comprehensive income (loss), before tax	45,070	(91,719)	32,288
Income tax expense (benefit) related to components of other comprehensive income	15,464	(31,868)	21,936
Other comprehensive income (loss), net of tax	29,606	(59,851)	10,352
Comprehensive income	$ 175,235	$ 110,275	$ 132,415

See accompanying notes to condensed financial statements.

SUPPLEMENTAL SCHEDULE I

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)

HEALTH NET, INC.

CONDENSED BALANCE SHEETS
(Amounts in thousands)

	December 31, 2014	December 31, 2013
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 61,212	$ 131,350
Investments—available for sale	—	78,242
Other assets	36,740	30,965
Deferred taxes	11,538	16,158
Assets held for sale	50,000	—
Due from subsidiaries	128,967	177,957
Total current assets	288,457	434,672
Property and equipment, net	53,016	162,679
Goodwill	312,732	319,732
Other intangible assets, net	573	1,198
Investment in subsidiaries	3,060,191	2,608,631
Deferred taxes	36,453	6,523
Other assets	70,760	71,661
Total Assets	$ 3,822,182	$ 3,605,096
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Due to subsidiaries	$ 284,654	$ 237,555
Deferred taxes	34,684	—
Other liabilities	130,580	100,755
Total current liabilities	449,918	338,310
Intercompany notes payable—long term	1,047,947	977,233
Long term debt	499,504	499,300
Other liabilities	115,591	161,442
Total Liabilities	2,112,960	1,976,285
Commitments and contingencies		
Stockholders' Equity:		
Common stock	153	150
Additional paid-in capital	1,444,705	1,377,624

Treasury common stock, at cost	(2,341,652)	(2,179,744)
CDIx552		
Retained earnings	2,609,277	2,463,648
Accumulated other comprehensive income	(3,261)	(32,867)
Total Stockholders' Equity	1,709,222	1,628,811
Total Liabilities and Stockholders' Equity	$ 3,822,182	$ 3,605,096

See accompanying notes to condensed financial statements.

SUPPLEMENTAL SCHEDULE I

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)

HEALTH NET, INC.

CONDENSED STATEMENTS OF CASH FLOWS
(Amounts in thousands)

	Year Ended December 31,		
	2014	**2013**	**2012**
NET CASH FLOWS PROVIDED BY OPERATING ACTIVITIES	$ 153,063	$ 111,385	$ 165,141
CASH FLOWS FROM INVESTING ACTIVITIES:			
Sales on investments	81,263	6,060	—
Maturities of investments	1,512	877	—
Purchases of investments	(3,032)	(6,841)	—
Purchases of property and equipment	(62,491)	(53,632)	(68,116)
Notes receivable due from subsidiaries	—	—	7,000
Capital contributions returned to Parent	—	2,300	1,500
Capital contributions to subsidiaries	(188,000)	(7,500)	(17,560)
Sales (purchases) of restricted investments and other	—	161	876
Net cash used in investing activities	(170,748)	(58,575)	(76,300)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Net (decrease) increase in checks outstanding, net of deposits	(46)	5	(44)
Excess tax benefit on share-based compensation	1,701	287	3,222
Net borrowings from subsidiaries	70,714	39,487	(9,103)
Proceeds from exercise of stock options and employee stock purchases	27,727	10,762	16,941
Proceeds from issuance of notes and other financing arrangements	—	345,000	110,000
Repayment of debt under financing arrangements	—	(345,000)	(122,500)
Repurchase of common stock	(152,549)	(77,810)	(69,496)
Net cash used in financing activities	(52,453)	(27,269)	(70,980)
Net (decrease) increase in cash and cash equivalents	(70,138)	25,541	17,861
Cash and cash equivalents, beginning of period	131,350	105,809	87,948
Cash and cash equivalents, end of period	$ 61,212	$ 131,350	$ 105,809
SUPPLEMENTAL CASH FLOWS DISCLOSURE:			
Interest paid	$ 29,670	$ 30,789	$ 31,134
Income taxes paid	83,499	80,119	5,001

See accompanying notes to condensed financial statements.

SUPPLEMENTAL SCHEDULE I
CONDENSED FINANCIAL INFORMATION OF REGISTRANT
(PARENT COMPANY ONLY)
HEALTH NET, INC.
NOTE TO CONDENSED FINANCIAL STATEMENTS

Note 1—Basis of Presentation

Health Net, Inc.’s ("HNT") investment in subsidiaries is stated at cost plus equity in undistributed earnings (losses) of subsidiaries. HNT’s share of net income (loss) of its unconsolidated subsidiaries is included in consolidated income using the equity method.

This condensed financial information of registrant (parent company only) should be read in conjunction with the consolidated financial statements of Health Net, Inc. and subsidiaries.

Note 2—Subsidiary Transactions

Dividends from Subsidiaries

HNT received cash dividends from its subsidiaries in the amounts of $61,750,000, $46,519,000 and $140,000,000 during the years ended December 31, 2014, 2013 and 2012, respectively.

EXHIBIT INDEX

Exhibit Number	Description
+^2.1	Stock Purchase Agreement, dated as of July 20, 2009, by and among Health Net, Inc., Health Net of the Northeast, Inc., Oxford Health Plans, LLC and solely with respect to section 8.16 thereof, UnitedHealth Group Incorporated (filed as Exhibit 2.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (File No. 1-12718) and incorporated herein by reference).
^2.2	Restated Amendment No. 1 to Stock Purchase Agreement, effective as of December 11, 2009, by and among Health Net, Inc., Health Net of the Northeast, Inc., Oxford Health Plans, LLC and UnitedHealth Group Incorporated (filed as Exhibit 2.2 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 1-12718) and incorporated herein by reference).
+2.3	Asset Purchase Agreement, dated as of January 6, 2012, between Health Net Life Insurance Company and Pennsylvania Life Insurance Company (filed as Exhibit 2.3 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
+2.4	Amendment No. 1 to Asset Purchase Agreement, dated as of March 31, 2012, between Health Net Life Insurance Company and Pennsylvania Life Insurance Company, (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012 (File No. 1-12718) and incorporated herein by reference).
3.1	Seventh Amended and Restated Certificate of Incorporation of Health Net, Inc. (filed as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011 (File No. 1-12718) and incorporated herein by reference).
3.2	Eleventh Amended and Restated Bylaws of Health Net, Inc. (filed as Exhibit 3.1 to the Company's Current Report on Form 8-K filed with the SEC on January 28, 2014 (File No. 1-12718) and incorporated herein by reference).
4.1	Specimen Common Stock Certificate (filed as Exhibit 8 to the Company's Registration Statement on Form 8-A/A (Amendment No. 3) on July 26, 2004 (File No. 1-12718) and incorporated herein by reference).
4.2	Rights Agreement, dated as of July 27, 2006, by and between Heath Net, Inc. and Wells Fargo Bank, N.A., as Rights Agent (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed with the SEC on July 28, 2006 (File No. 1-12718) and incorporated herein by reference).
4.3	Indenture, dated as of May 18, 2007, by and between Health Net, Inc. as issuer, and The Bank of New York Trust Company, N.A., as trustee (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed with the SEC on May 18, 2007 (File No. 1-12718) and incorporated herein by reference).
4.4	Officer's Certificate, dated May 18, 2007, establishing the terms and form of the Company's $300,000,000 aggregate principal amount of its 6.375% Senior Notes due 2017 (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed with the SEC on May 18, 2007 (File No. 1-12718) and incorporated herein by reference).
4.5	Officer's Certificate, dated May 31, 2007, establishing the terms and form of the Company's $100,000,000 aggregate principal amount of its 6.375% Senior Notes due 2017 (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed with the SEC on May 31, 2007 (File No. 1-12718) and incorporated herein by reference).
*10.1	Amended and Restated Employment Agreement, dated as of December 14, 2009, by and between Health Net, Inc. and Angelee F. Bouchard (filed as Exhibit 10.1 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 1-12718) and incorporated herein by reference).
†*10.2	Transition Services, Separation Agreement and Release of All Claims, dated as of October 20, 2014, by and between Health Net, Inc. and Angelee F. Bouchard, a copy of which is filed herewith.
*10.3	Amended and Restated Employment Agreement, dated as of December 3, 2008, by and between Health Net, Inc. and Joseph C. Capezza (filed as Exhibit 10.5 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.4	Consulting Services Agreement, dated as of September 3, 2014, by and between Health Net, Inc. and Joseph C. Capezza (filed as Exhibit 10.1 of the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2014 (File No. 1-12718) and incorporated herein by reference).
*10.5	Amended and Restated Employment Agreement, dated as of December 3, 2008, by and between Health Net, Inc. and Jay M. Gellert (filed as Exhibit 10.3 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).

Exhibit Number	Description
†*10.6	Amended and Restated Employment Agreement, dated as of February 25, 2015, by and between Health Net, Inc. and Juanell Hefner, a copy of which is filed herewith.
†*10.7	Amended and Restated Employment Agreement, dated as of February 25, 2015, by and between Health Net, Inc. and Scott D. Law, a copy of which is filed herewith.
*10.8	Amended and Restated Employment Agreement, dated as of December 3, 2008, by and between Health Net, Inc. and Karin Mayhew (filed as Exhibit 10.1 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
†*10.9	Amended and Restated Employment Agreement, dated as of February 24, 2015, by and between Health Net, Inc. and Steven Sell, a copy of which is filed herewith.
†*10.10	Amended and Restated Employment Agreement, dated as of February 24, 2015, by and between Health Net, Inc. and Steve Tough, a copy of which is filed herewith.
*10.11	Amended and Restated Employment Agreement, dated as of December 3, 2008, by and between Health Net, Inc. and James E. Woys (filed as Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.12	Certain Compensation and Benefit Arrangements with Health Net, Inc.'s Non-Employee Directors, as amended and restated on July 18, 2014 (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014 (File No. 1-12718) and incorporated herein by reference).
*10.13	Form of Nonqualified Stock Option Agreement utilized for eligible employees of Health Net, Inc. under the 2006 Long-Term Incentive Plan, as amended (filed as Exhibit 10.15 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
*10.14	Form of Nonqualified Stock Option Agreement utilized for eligible employees of Health Net, Inc. under the 2006 Long-Term Incentive Plan, as amended (filed as Exhibit 10.2 to the Company's Current Report on Form 8-K filed with the SEC on June 17, 2010 (File No. 1-12718) and incorporated herein by reference).
*10.15	Form of Nonqualified Stock Option Agreement utilized for eligible employees of Health Net, Inc. under the 2006 Long-Term Incentive Plan, as amended (filed as Exhibit 10.14 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 1-12718) and incorporated herein by reference).
*10.16	Form of Nonqualified Stock Option Agreement utilized for eligible employees of Health Net, Inc. (filed as Exhibit 10.4 to the Company's Current Report on Form 8-K filed with the SEC on January 21, 2009 (File No. 1-12718) and incorporated herein by reference).
*10.17	Form of Nonqualified Stock Option Agreement utilized for eligible employees of Health Net, Inc. (filed as Exhibit 10.3 to the Company's Current Report on Form 8-K filed with the SEC on March 6, 2006 (File No. 1-12718) and incorporated herein by reference).
*10.18	Form of Nonqualified Stock Option Agreement utilized for Tier 1, 2 and 3 officers of Health Net, Inc. (filed as Exhibit 10.23 to the Company's Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 1-12718) and incorporated herein by reference).
*10.19	Form of Nonqualified Stock Option Agreement utilized for Tier 1 officers of Health Net, Inc. (filed as Exhibit 10.20 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2002 (File No. 1-12718) and incorporated herein by reference).
*10.20	Form of Nonqualified Stock Option Agreement utilized for Tier 2 officers of Health Net, Inc. under the Health Net, Inc. 1998 Stock Option Plan (filed as Exhibit 10.15 to the Company's Annual Report on Form 10-K for the year ended December 31, 2003 (File No. 1-12718) and incorporated herein by reference).
*10.21	Form of Nonqualified Stock Option Agreement utilized for Tier 3 officers of Health Net, Inc. under the Health Net, Inc. 1998 Stock Option Plan (filed as Exhibit 10.17 to the Company's Annual Report on Form 10-K for the year ended December 31, 2003 (File No. 1-12718) and incorporated herein by reference).
*10.22	Form of Restricted Stock Agreement utilized for eligible employees of Health Net, Inc. (filed as Exhibit 10.26 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).

Exhibit Number	Description
*10.23	Form of Restricted Stock Unit Agreement utilized for eligible employees of Health Net, Inc. (filed as Exhibit 10.29 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
*10.24	Form of Restricted Stock Unit Agreement utilized for eligible employees of Health Net, Inc. (filed as Exhibit 10.4 to the Company's Current Report on Form 8-K filed with the SEC on June 17, 2010 (File No. 1-12718) and incorporated herein by reference).
†*10.25	Form of Performance Share Award Agreement utilized for eligible employees of Health Net, Inc., a copy of which is filed herewith.
*10.26	Form of Performance Share Award Agreement utilized for eligible employees of Health Net, Inc. (filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013 (File No. 1-12718) and incorporated herein by reference).
*10.27	Form of Nonqualified Stock Option Agreement utilized for non-employee directors under the 2006 Long-Term Incentive Plan, as amended (filed as Exhibit 10.36 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
*10.28	Form of Nonqualified Stock Option Agreement utilized for non-employee directors under the 2006 Long-Term Incentive Plan, as amended (filed as Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009 File No. 1-12718 and incorporated herein by reference).
*10.29	Form of Nonqualified Stock Option Agreement utilized for non-employee directors under the 2006 Long-Term Incentive Plan (filed as Exhibit 10.5 to the Company's Current Report on Form 8-K filed with the SEC on January 21, 2009 (File No. 1-12718) and incorporated herein by reference).
*10.30	Form of Nonqualified Stock Option Agreement utilized for non-employee directors under the 2006 Long-Term Incentive Plan (filed as Exhibit 10.2 to the Company's Current Report on Form 8-K filed with the SEC on May 15, 2006 (File No. 1-12718) and incorporated herein by reference).
*10.31	Form of Nonqualified Stock Option Agreement utilized for non-employee directors under the Health Net, Inc. Third Amended and Restated Non-Employee Director Stock Option Plan (filed as Exhibit 10.22 to the Company's Annual Report on Form 10-K for the year ended December 31, 2004 (File No. 1-12718) and incorporated herein by reference).
*10.32	Form of Nonqualified Stock Option Agreement utilized for non-employee directors under the Health Net, Inc. Amended and Restated 1998 Stock Option Plan (filed as Exhibit 10.23 to the Company's Annual Report on Form 10-K for the year ended December 31, 2004 (File No. 1-12718) and incorporated herein by reference).
*10.33	Form of Restricted Stock Unit Agreement utilized for non-employee directors of Health Net, Inc. (filed as Exhibit 10.44 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
*10.34	Form of Restricted Stock Unit Agreement utilized for non-employee directors of Health Net, Inc. under the 2006 Long-Term Incentive Plan (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2011 (File No. 1-12718) and incorporated herein by reference).
*10.35	Health Net, Inc. Deferred Compensation Plan, as amended and restated effective January 1, 2010 (filed as Exhibit 10.35 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009 and (File No. 1-12718) incorporated herein by reference).
*10.36	Amendment Number One to the Health Net, Inc. Deferred Compensation Plan (As Amended and Restated effective January 1, 2010) (filed as Exhibit 10.33 to the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (File No. 1-12718) and incorporated herein by reference).
*10.37	Health Net, Inc. Deferred Compensation Plan for Directors, as amended and restated effective December 1, 2009 (filed as Exhibit 10.36 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 1-12718) and incorporated herein by reference).
*10.38	Amendment Number One to the Health Net, Inc. Deferred Compensation Plan for Directors (As Amended and Restated effective December 1, 2009) (filed as Exhibit 10.35 to the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (File No. 1-12718) and incorporated herein by reference).

Exhibit Number	Description
*10.39	Foundation Health Systems, Inc. Deferred Compensation Plan Trust Agreement effective September 1, 1998 between Foundation Health Systems, Inc. and Union Bank of California (filed as Exhibit 10.31 to the Company's Annual Report on Form 10-K for the year ended December 31, 1998 (File No. 1-12718) and incorporated herein by reference).
*10.40	Amendment Number One to the Health Net, Inc. Deferred Compensation Plan Trust Agreement between Health Net, Inc. and Union Bank of California, adopted January 1, 2001 (filed as Exhibit 10.49 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
*10.41	Foundation Health Systems, Inc. Amended and Restated 1998 Stock Option Plan (filed as Exhibit 99 to the Company's Current Report on Form 8-K filed with the SEC on August 16, 2004 (File No. 1-12718) and incorporated herein by reference).
*10.42	Amendment No. 1 to Foundation Health Systems, Inc. Amended and Restated 1998 Stock Option Plan (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the SEC on March 6, 2006 (File No. 1-12718) and incorporated herein by reference).
*10.43	Amendment No. 2 to Foundation Health Systems, Inc. Amended and Restated 1998 Stock Option Plan (filed as Exhibit 10.32 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.44	Amendment No. 3 to Foundation Health Systems, Inc. Amended and Restated 1998 Stock Option Plan (filed as Exhibit 10.41 to the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (File No. 1-12718) and incorporated herein by reference).
*10.45	Foundation Health Systems, Inc. Third Amended and Restated Non-Employee Director Stock Option Plan (filed as Exhibit 10.46 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 1997 (File No. 1-12718) and incorporated herein by reference).
*10.46	Amendment Number One to the Foundation Health Systems, Inc. Third Amended and Restated Non-Employee Director Stock Option Plan (filed as Exhibit 10.43 to the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (File No. 1-12718) and incorporated herein by reference).
*10.47	Health Net, Inc. 2005 Long-Term Incentive Plan (filed as Exhibit 10.3 to the Company's Current Report on Form 8-K filed with the SEC on May 13, 2005 (File No. 1-12718) and incorporated herein by reference).
*10.48	Amendment No. 1 to Health Net, Inc. 2005 Long-Term Incentive Plan (filed as Exhibit 10.35 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.49	Amendment No. 2 to Health Net, Inc. 2005 Long-Term Incentive Plan (filed as Exhibit 10.36 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.50	Amendment No. 3 to the Health Net, Inc. 2005 Long-Term Incentive Plan (filed as Exhibit 10.49 to the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (File No. 1-12718) and incorporated herein by reference).
*10.51	Health Net, Inc. 2006 Long-Term Incentive Plan (as filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the SEC on May 15, 2006 (File No. 1-12718) and incorporated herein by reference).
*10.52	Amendment No. 1 to the Health Net, Inc. 2006 Long-Term Incentive Plan (filed as Exhibit 10.38 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.53	Amendment No. 2 to the Health Net, Inc. 2006 Long-Term Incentive Plan (filed as Appendix B to the Company's Definitive Proxy Statement filed with the SEC on April 8, 2009 (File No. 1-12718) and incorporated herein by reference).
*10.54	Amendment No. 3 to the Health Net, Inc. 2006 Long-Term Incentive Plan (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2013 (File No. 1-12718) and incorporated herein by reference).
*10.55	Amendment No. 4 to the Health Net, Inc. 2006 Long-Term Incentive Plan (filed as Exhibit 10.54 to the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (File No. 1-12718) and incorporated herein by reference).

Exhibit Number	Description
*10.56	Health Net, Inc. Management Incentive Plan (filed as Exhibit 10.40 to the Company's Annual Report on Form 10-K for the year ended December 31, 2004 (File No. 1-12718) and incorporated herein by reference).
*10.57	Amendment No. 1 to the Health Net, Inc. Management Incentive Plan (filed as Exhibit 10.45 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.58	Addendum A to the Health Net, Inc. Management Incentive Plan (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009 (File No. 1-12718) and incorporated herein by reference).
*10.59	2013 Restatement of the Health Net, Inc. 401(k) Savings Plan (effective January 1, 2013) (filed as Exhibit 10.59 to the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (File No. 1-12718) and incorporated herein by reference).
†*10.60	First Amendment to the Health Net, Inc. 401(k) Savings Plan (as amended and restated effective January 1, 2013), a copy of which is filed herewith.
*10.61	Health Net, Inc. Supplemental Executive Retirement Plan, amended and restated effective as of January 1, 2008 (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the SEC on December 9, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.62	Amended and Restated Deferred Compensation Plan of Foundation Health Corporation (filed as Exhibit 10.99 to Foundation Health Corporation's Annual Report on Form 10-K for the year ended June 30, 1995 (File No. 1-10540) and incorporated herein by reference).
*10.63	Amendment Number One Through Three to the Amended and Restated Deferred Compensation Plan of Foundation Health Corporation (filed as Exhibit 10.49 to the Company's Annual Report on Form 10-K for the year ended December 31, 2004 (File No. 1-12718) and incorporated herein by reference).
*10.64	Foundation Health Corporation Executive Retiree Medical Plan, as amended and restated effective April 25, 1995 (filed as Exhibit 10.101 to Foundation Health Corporation's Annual Report on Form 10-K for the year ended June 30, 1995 (File No. 1-10540) and incorporated herein by reference).
*10.65	Form of Amended and Restated Indemnification Agreement for directors and executive officers of Health Net, Inc. (filed as Exhibit 10.3 to the Company's Current Report on Form 8-K filed with the SEC on December 9, 2008 (File No. 1-12718) and incorporated herein by reference).
*10.66	Health Net, Inc. Compensation Recovery Policy (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the SEC on June 17, 2010 (File No. 1-12718) and incorporated herein by reference).
^10.67	Credit Agreement, dated as of October 24, 2011, by and among Health Net, Inc., Bank of America, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer, and the other lenders party thereto from time to time (filed as Exhibit 10 to the Company's Current Report on Form 8-K filed with the SEC on October 28, 2011 (File No. 1-12718) and incorporated herein by reference).
^10.68	Master Agreement, dated August 19, 2008, between Health Net, Inc. and International Business Machines Corporation (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2008 (File No. 1-12718) and incorporated herein by reference).
^10.69	Amendment No. 01 to Services Agreement, dated and effective as of August 19, 2008, between Health Net, Inc. and International Business Machines Corporation (filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011 (File No. 1-12718) and incorporated herein by reference).
^10.70	Amendment No. 02 to Services Agreement, dated and effective as of August 19, 2008, between Health Net, Inc. and International Business Machines Corporation (filed as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011 (File No. 1-12718) and incorporated herein by reference).
^10.71	Amendment No. 3 to Master Agreement, effective as of April 25, 2011, between Health Net, Inc. and International Business Machines Corporation (filed as Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011 (File No. 1-12718) and incorporated herein by reference).

Exhibit Number	Description
^10.72	Amendment No. 4 to the Master Services Agreement, dated January 1, 2014, by and between Health Net, Inc. and International Business Machines Corporation (filed as Exhibit 10.2 of the Company's Quarterly Report on Form 10-Q/A for the quarter ended June 30, 2014 (File No. 1-12718) and incorporated herein by reference).
^10.73	Master Services Agreement, dated September 30, 2008, between Health Net, Inc. and Cognizant Technology Solutions U.S. Corporation (filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2008 (File No. 1-12718) and incorporated herein by reference).
^10.74	Amendment No. 2010-01 to Master Services Agreement, effective as of April 15, 2010, between Health Net, Inc. and Cognizant Technology Solutions U.S. Corporation (filed as Exhibit 10.85 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
^10.75	Amendment No. 2010-02 to Master Services Agreement, effective as of April 1, 2010, between Health Net, Inc. and Cognizant Technology Solutions U.S. Corporation (filed as Exhibit 10.86 to the Company's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718) and incorporated herein by reference).
10.76	Amendment No. 3 to Master Services Agreement, dated August 9, 2012, by and between Health Net, Inc. and Cognizant Technology Solutions US Corporation (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012 (File No. 1-12718) and incorporated herein by reference).
^10.77	Amendment No. 4 to the Master Services Agreement, dated January 1, 2014, by and between Health Net, Inc. and Cognizant Technology Solutions US Corporation (filed as Exhibit 10.1 of the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014 (File No. 1-12718) and incorporated herein by reference).
^†10.78	Amendment No. 5 to the Master Services Agreement, dated as of November 2, 2014, by and between Health Net, Inc. and Cognizant Technology Solutions US Corporation, a copy of which is filed herewith.
10.79	Transitional Trademark License Agreement, effective as of December 11, 2009, by and among Health Net, Inc., Health Net of Connecticut, Inc., Health Net of New York, Inc., Health Net Insurance of New York, Inc., FOHP, Inc., Health Net of New Jersey, Inc. and Health Net Services (Bermuda) Ltd. (filed as Exhibit 10.107 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 1-12718) and incorporated herein by reference).
+^†10.80	Asset Purchase Agreement, dated November 2, 2014, by and between Health Net, Inc. and Cognizant Healthcare Services, LLC, a copy of which is filed herewith.
P^†10.81	Amended and Restated Master Services Agreement, dated as of November 21, 2014, by and between Cognizant Healthcare Services, LLC and Health Net, Inc.
†11	Statement relative to computation of per share earnings of the Company (included in Note 2 to the consolidated financial statements included as part of this Annual Report on Form 10-K).
†21	Subsidiaries of Health Net, Inc., a copy of which is filed herewith.
†23	Consent of Deloitte & Touche LLP, Independent Registered Public Accounting Firm, a copy of which is filed herewith.
†31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002, a copy of which is filed herewith.
†31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002, a copy of which is filed herewith.
†32	Certification of Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, a copy of which is filed herewith.

Exhibit Number	Description
101	The following materials from Health Net, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2014, formatted in XBRL (eXtensible Business Reporting Language): (1) Consolidated Statements of Operations for the years ended December 31, 2014, December 31, 2013 and December 31, 2012, (2) Consolidated Statements of Comprehensive Income for the years ended December 31, 2014, December 31, 2013 and December 31, 2012, (3) Consolidated Balance Sheets as of December 31, 2014 and December 31, 2013, (4) Consolidated Statements of Stockholders' Equity for the years ended December 31, 2014, December 31, 2013 and December 31, 2012, (5) Consolidated Statements of Cash Flows for the years ended December 31, 2014, December 31, 2013 and December 31, 2012, and (6) Notes to Consolidated Financial Statements.

____

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

† A copy of the exhibit is being filed with this Annual Report on Form 10-K.

^ Portions of this exhibit have been redacted pursuant to a request for confidential treatment under Rule 24b-2 of the Securities Exchange Act of 1934, as amended, that has been submitted separately to the Securities and Exchange Commission.

+ Schedules and exhibits have been omitted pursuant to Item 601(b)(2) of Regulation S-K. The Company undertakes to furnish supplemental copies of any of the omitted schedules and exhibits upon request by the U.S. Securities and Exchange Commission.

P This exhibit has been filed in paper format on Form TH under cover of Form SE in accordance with Rule 201 of Reg. S-T.

Exhibit 10.2

TRANSITION SERVICES, SEPARATION AGREEMENT AND RELEASE OF ALL CLAIMS

This **TRANSITION SERVICES, SEPARATION AGREEMENT AND RELEASE OF ALL CLAIMS** (this "***Release***" or "***Agreement***") is made and entered into by and between Health Net, Inc. and its affiliates and subsidiaries (hereinafter referred to as the "***Company***") and Angelee F. Bouchard (hereinafter referred to as the "***Employee***").

WHEREAS, the Company and the Employee previously entered into an Amended and Restated Employment Agreement effective December 14, 2009 (the "***Employment Agreement***") that currently governs the terms of the Employee's employment with the Company.

WHEREAS, the Employee desires to resign and voluntarily terminate her employment with the Company following a Transition Period (as defined below);

WHEREAS, pursuant to the terms and conditions set forth herein, the parties desire to set forth their mutual obligations during the Transition Period and thereafter;

WHEREAS, the Company and the Employee mutually desire to terminate the employment relationship, subject to the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual promises and conditions set forth herein, and for other good and sufficient consideration, the sufficiency of which is hereby acknowledged, the Company and the Employee agree as follows:

1. **Transition Services and Separation From Service**.

(a) The Employee agrees to provide services to the Company on a transitional basis pursuant to the terms of this Agreement from the Effective Date (as defined below) until March 31, 2015 (the "***Transition Period***"). During the Transition Period, the Employee will continue in her current roles as Senior Vice President, General Counsel and Corporate Secretary of the Company and during such period will continue to perform the duties as set forth in Section 1.A. of the Employment Agreement. During the period that the Employee is the Senior Vice President, General Counsel and Corporate Secretary of the Company, the Employee will continue to be subject to the Company's Executive Officer Stock Ownership Policy, as set forth in Section 8.C of the Employment Agreement.

(b) If the Company hires a new General Counsel prior to the end of the Transition Period, the Employee agrees that her title will automatically change to Special Counsel for the remainder of the Transition Period, in which case she will be assigned, and agrees to carry out, all duties and responsibilities commensurate with such position within the Company in good faith, as determined by the new General Counsel, and to the best of her ability, including, but not limited to, assisting with an efficient transition of some or all of those duties and responsibilities her successor as requested by the Company.

(c) During the Transition Period, the Company will allow the Employee to work from Denver, Colorado rather than the Company's headquarters in Woodland Hills, CA.

(d) Following the conclusion of the Transition Period, the Employee will be on paid time off until May 26, 2015 (the "***Resignation Date***" and such period, the "***PTO Period***"). During the PTO Period, the Employee be treated like any other employee of the Company taking PTO and, therefore, will not be required to report to work or otherwise perform any duties or provide active services to the Company during the PTO Period.

(e) During the Transition Period and the PTO Period, the Employee shall continue to receive her base salary at her current annual rate of base salary of $527,875, which shall be paid in accordance with the Company's normal payroll practices, subject to applicable federal, state, local and employment tax withholding.

(f) If the Employee remains employed through and including December 31, 2014, the Employee shall be eligible to receive an annual bonus for calendar year 2014 subject to the terms of the Management Incentive Plan (the "***MIP***") based on actual performance against the applicable metrics for calendar year 2014 (the "***2014 Bonus***"). The 2014 Bonus, if any, will be paid to the Employee at the same time annual bonuses under the MIP are paid to other the Employees of the Company. The Employee will not be eligible for an annual bonus for calendar year 2015 under the MIP or otherwise. Additionally, if the Employee has a Separation Date (as defined below) prior to December 31, 2014, the Employee will not receive the 2014 Bonus.

(g) During the Transition Period, the Employee shall continue to vest in any outstanding equity awards, but vesting will cease during the PTO Period. During the Transition Period and the PTO Period, the Employee shall remain eligible to participate in the Employee benefits offered by the Company in accordance with the terms of such the Employee benefit plans, including, but not limited to, the benefits set forth in Sections 7.A, 7.B, 7.C and 7.E of the Employment Agreement.

(h) Absent a written agreement to the contrary, the Employee's employment relationship with the Company will terminate pursuant to the terms of this Agreement upon earliest of: (i) the Resignation Date; (ii) the date the Employee voluntarily terminates employment; or (iii) the date the Company terminates the employment of the Employee, either with or without Cause (as defined in the Employment Agreement) or as a result of death or Disability (as defined in the Employment Agreement). The date on which this Agreement terminates pursuant to this Section 1(h) hereof is referred to in this Agreement as the "***Separation Date***". Nothing herein shall alter the "at-will" nature of the Employee's employment with the Company or modify the Section 9 of the Employment Agreement. Following Separation Date, the Employee shall not represent to anyone that she is an employee of the Company and shall not say or do anything purporting to bind the Company.

(i) Except to the extent specifically amended under this Agreement, the terms of the Employment Agreement shall remain in effect, specifically including, but in no way limiting, Sections 3, 12 and 13 of the Employment Agreement.

2. **Severance and Change in Control Benefits**.

(a) The Employee acknowledges and agrees that she is not entitled to, and specifically waives any right to, the severance benefits set forth in Section 10.A. of the Employment Agreement. Notwithstanding the forgoing, if the Company terminates the Employee's employment without

Cause (as defined in the Employment Agreement) prior to the conclusion of the Transition Period, the Employee will be eligible for the severance benefits set forth in Section 10.A of the Employment Agreement, subject to the terms and conditions set forth in the Employment Agreement.

(b) If the Company consummates a Change in Control (as defined in the Employment Agreement) prior to the conclusion of the Transition Period and the Employee has not incurred a Separation Date, upon the Employee's Separation Date, the Employee will be entitled to the severance benefits set forth in Section 10.B. of the Employment Agreement, subject to the terms and conditions set forth in the Employment Agreement. For the avoidance of doubt, if the Company consummates a Change in Control after the Transition Period, but during the PTO Period, the Employee will not be entitled to the severance benefits set forth in Section 10.B. of the Employment Agreement.

(c) If the Employee remains employed by the Company through the conclusion of the Transition Period, and the Employee executes a release of claims in favor of the Company, in substantially the form attached to the Employment Agreement as Exhibit A, that becomes effective and irrevocable no later than thirty (30) days following the Separation Date (such deadline, the "***Release Deadline***"), the Company will pay the Employee a lump sum cash payment equal to two hundred and fifty thousand dollars ($250,000) at the conclusion of the Release Deadline.

(d) The Employee acknowledges and agrees that benefits set forth in Sections 1 and 2 hereof are benefit to which the Employee is not otherwise entitled, and the Employee understands that if she does not sign this Release, or if she revokes acceptance of this Release, the Employee shall not be entitled to such benefits.

(e) By signing below, the Employee confirms and agrees that as of the Effective Date, the Employee has been paid all compensation due the Employee as of the Effective Date by virtue of her employment, in keeping with the Company's policy and practice.

3. **Release**.

(a) *General Release*. In return for the consideration set forth in Sections 1 and 2 above, the Employee, on behalf of herself, as well as the Employee's heirs, beneficiaries, successors, representatives, trustees, administrators and assigns, freely and voluntarily hereby waives and releases the Company, and each of its past, present and future officers, directors, shareholders, the Employees, consultants, accountants, attorneys, agents, managers, insurers, sureties, parent and sister corporations, divisions, subsidiary corporations and entities, partners, joint venturers and affiliates (and each of their respective beneficiaries, successors, representatives and assigns) and all persons acting in concert with them (collectively, "***Affiliates***") from any and all claims, demands, damages, debts, liabilities, controversies, obligations, actions or causes of action of any nature whatsoever, whether based on tort, statute, contract, indemnity, rescission or any other theory of recovery, and whether for compensatory, punitive, equitable or other relief, whether known, unknown, suspected or unsuspected, against the Company and/or its Affiliates, including without limitation claims which may have arisen or may in the future arise in connection with any event that occurred on or before the date of the Employee's execution of this Release.

These claims include but are not limited to claims arising under federal, state and local statutory or common law, including, but not limited to the Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq. ("***ADEA***"); Title VII of the Civil Rights Act of 1964, as amended by the Civil Rights Act of 1991, 42 U.S.C. § 2000 et seq.; Equal Pay Act, 29 U.S.C. § 206(d); the Civil Rights Act of 1866, 42 U.S.C. § 1981; the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; the False Claims Act, 31 U.S.C. § 3729 et seq.; the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq.; the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2101 et seq.; the California Fair Employment and Housing Act, Cal. Lab. Code § 12940 et seq.; the California Equal Pay Law, Cal. Lab. Code §§ 1197.5(a),1199.5; the Moore-Brown-Roberti Family Rights Act of 1991, Cal. Gov't Code §§12945.2, 19702.3; the California WARN Act, Cal. Lab. Code § 1400 et seq,; the California Labor Code; the California Constitution; (all as amended) claims arising out of any legal restrictions on the Company's right to terminate its the Employees; or claims arising under state and federal whistleblower statutes to the maximum extent permitted by law. Nothing herein shall be construed to impede the Employee from communicating directly with, cooperating with or providing information to any government regulator.

(b) *Unknown Claims*. The Employee expressly waives any right or claim of right to assert hereafter that any claim, demand, obligation and/or cause of action has, through ignorance, oversight or error, been omitted from the terms of this Release. The Employee makes this waiver with full knowledge of her rights and with specific intent to release both her known and unknown claims, and therefore specifically waives her rights under Section 1542 of the Civil Code of California or other similar provisions of any other applicable law (collectively, "***Section 1542***"), which reads as follows:

> **"A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected her settlement with the debtor."**

The Employee understands and acknowledges the significance and consequence of this Release and of such specific waiver of Section 1542, and expressly agrees that this Agreement shall be given full force and effect according to each and all of its express terms and provisions, including those relating to unknown and unsuspected claims, demands, obligations and causes of action herein above specified.

(c) *Claims Not Released*. This Release does not waive rights or claims under federal or state law that the Employee cannot waive by private agreement, including, but not limited to those she may have under Sections 2800 and 2802 of the California Labor Code, the Employee's right to file a claim for unemployment benefits, worker's compensation benefits, claims under the Fair Labor

Standards Act, health insurance benefits under COBRA, or claims with regards to vested benefits under a retirement plan governed by ERISA.

(d) *Review and Revocation*. In accordance with the Older Workers Benefit Protection Act, the Employee acknowledges and agrees this Agreement includes a waiver and release of all claims that the Employee have or may have under the ADEA. With respect to the release of claims under the ADEA, the Employee acknowledges that:

(i) This Agreement is written in a manner calculated to be understood by the Employee and the Employee understands it.

(ii) The waiver and release of claims under the ADEA contained in this Agreement does not cover rights or claims that may arise after the date on which the Employee signs this Agreement.

(iii) This Agreement provides for consideration in addition to anything of value to which the Employee is already entitled.

(iv) The Employee is hereby advised to consult an attorney before signing this Agreement.

(v) The Employee has been granted twenty-one (21) days after receiving this Agreement to decide whether or not to sign this Agreement. If the Employee signs this Agreement prior to the expiration of the twenty-one (21) day period, the Employee does so voluntarily and after having had the opportunity to consult with an attorney, and the Employee hereby waives the remainder of the twenty-one (21) day period.

(vi) The Employee has the right to revoke this Agreement within seven (7) days of signing this Agreement, and this Agreement shall not be enforceable or effective until the eighth (8th) day after she signs this Agreement (the "***Effective Date***").

(vii) In the event this Agreement is revoked, this Agreement will be null and void in its entirety, and the Employee will not be entitled to the vesting acceleration provided in Section 2 of this Agreement. If the Employee wishes to revoke this Agreement, the Employee must deliver written notice stating her intent to revoke this Agreement to Karin Mayhew, the Company's SVP, Organization Effectiveness, on or before 5:00 p.m. on the seventh (7th) day after the date on which the Employee signed this Agreement.

4. **No Future Actions**. To the extent permitted by law, the Employee agrees that the Employee shall not encourage, cooperate in, or initiate any suit or action of any kind, or voluntarily participate in same, individually or as a representative, witness or member of a class, under contract, law or regulation, federal, state or local, pertaining to any matter related to her employment with the Company. The Employee represents that she has not, to date, initiated (or caused to be initiated) any such suit or action.

The Employee agrees that if she, or anyone purporting to act on his behalf or under any assignment of claims from the Employee, hereafter commences any suit arising out of, based upon, or relating to any of the claims released by the Agreement or in any manner asserts against the Company and/or its Affiliates, any of the claims released hereunder, then, to the maximum extent permitted by law, the Employee will pay to the Company and/or its Affiliates, as applicable, in addition to any other damages caused to them thereby, all attorneys' fees incurred by the Company and/or its Affiliates, as applicable, in defending or otherwise responding to said suit or claim.

The foregoing shall not apply if the Employee is required to participate by legal process or other requirement of applicable law, provided that the Employee gives the Company notice if legal process is served on the Employee; or to any challenge by the Employee to the validity of any release herein of ADEA claims or to any to suit or action brought by the Employee to assert such a challenge.

Additionally, nothing in this Release precludes the Employee from participating in any investigation or proceeding before any federal or state agency, or governmental body, including, but not limited to, the Equal Employment Opportunity Commission, the Securities and Exchange Commission, and/or the Department of Justice. However, while the Employee may file a charge, provide information, or participate in any investigation or proceeding, by signing this Release, the Employee, to the maximum extent permitted by law, waives any right to bring a lawsuit against the Company, and waives any right to any individual monetary recovery in any such proceeding or lawsuit or in any proceeding brought based on any communication by the Employee to any federal, state or local government agency or department.

5. **Cooperation with the Company**. In addition, the Employee shall, without further compensation, cooperate with and assist the Company in the investigation of, preparation for or defense of any actual or threatened third party claim, investigation or proceeding involving the Company or its predecessors or affiliates and arising from or relating to, in whole or in part, the Employee's employment with the Company or its predecessors or affiliates for which the Company requests the Employee's assistance, which cooperation and assistance shall include, but not be limited to, providing truthful testimony and assisting in information and document gathering efforts. In connection herewith, it is agreed that the Company will use its reasonable best efforts to assure that any request for such cooperation will not unduly interfere with the Employee's other material business and personal obligations and commitments.

6. **Confidential Information**. To the maximum extent permitted by law, the Employee shall not, without the Company's written consent by an authorized representative, at any time prior or subsequent to the execution of this Release, disclose, use, remove or copy any Confidential Information, trade secret or proprietary information she acquired during the course of her employment by the Company. "***Confidential Information***," for purposes of this Agreement, includes any information not previously published or generally in the public domain. Confidential Information, trade secrets and proprietary information includes

without limitation, any technical, actuarial, economic, financial, procurement, provider, enrollee, customer, underwriting, contractual, managerial, marketing or other information of any type regarding the business in which the Company is engaged, but not including any previously published information or other information generally in the public domain. The Employee also agrees that she shall not without the Company's written consent by an authorized representative, directly or indirectly use the Company's trade secret information, including but not limited to customer lists, to solicit business of any customers of the Company (other than on behalf of the Company). The Employee acknowledges and agrees that any "***Invention***," including without limitation, any developments or discoveries by the Employee during the course of her employment with the Company through the date of execution of this Release resulting in patents, lists of customers, trade secrets, specialized know-how or other intellectual property useful in the then-current business of the Company and any original works of authority are the property of the Company and shall be used for the sole benefit of the Company. If not previously assigned to the Company, the Employee hereby assigns ownership of any and all Inventions to the Company, provided, however, that the provisions of this Agreement requiring assignment of Inventions to the Company do not apply to any invention which qualifies fully under the provisions of California Labor Code section 2870, which provides as follows:

"(a) Any provision in an employment agreement which provides that an the Employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the Employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either: (1) Relate at the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or (2) Result from any work performed by the Employee for the employer.

(b) To the extent a provision in an employment agreement purports to require an the Employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable."

This provision shall supplement, but not limit or supersede any other agreement between the Employee and the Company concerning any Confidential Information or other intellectual property.

7. **No Disparagement**. The Employee further agrees and acknowledges that in exchange for the consideration identified in Sections 1 and 2 above, she shall not make any disparaging comments and/or statements to anyone either orally or in writing about the Company and/or its Affiliates.

8. **No Admission**. Nothing contained herein shall be construed as an admission of any wrongful act, including, but not limited to, violation of any contract, express or implied, or any federal, state or local employment laws or regulations, and nothing contained herein shall be used for any purpose except in proceedings related to the enforcement of this Release.

9. **Arbitration of Disputes**. If there is any dispute between the Company and the Employee over the terms or obligations under this Release, that dispute shall be resolved by binding arbitration before a single neutral arbitrator who shall be a retired judge. The arbitration shall proceed in accordance with the then-current Employment Rules of the American Arbitration Association. The judgment of the arbitrator shall be final, binding and nonappealable, and may be entered in any state or federal court having jurisdiction thereafter. The arbitrator shall be bound to apply and follow the applicable state or federal laws in reaching a decision in this matter. Any disagreement regarding whether a dispute is required to be arbitrated pursuant to this Release shall be decided by the arbitrator. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall govern the interpretation and enforcement of this paragraph.

   Notwithstanding the above paragraph, the arbitration procedure shall not prohibit the Employee or the Company from seeking injunctive relief, including without limitation, temporary or preliminary injunctive relief, through any court of competent jurisdiction if such relief is not available or is not available in a timely manner, through arbitration.

10. **Confidentiality**. The Employee represents and agrees that she will keep the terms, amounts and facts of this Release completely confidential, and that she will not hereafter disclose any information concerning this Release to anyone except her immediate family, attorneys or accountants or taxing authorities, except as may be required by law. The Employee agrees that if the Employee discloses this Release to anyone in her immediate family, her attorney(s), or her accountant(s), the Employee will ensure that the individual to whom the Employee discloses the Agreement understands that she is also subject to this confidentiality provision. The Employee agrees that she is liable for any breach of this provision by his immediate family, attorney(s) or accountant(s), in the same manner and with the same consequences as if the Employee herself had breached this provision. This provision shall not apply to any information that becomes generally known as a result of disclosure by the Company.

11. **Severability**. Should any part, term or provision of this Release be declared and/or be determined by any court or arbitrator to be illegal or invalid, the validity of the remaining parts, terms or provisions shall not be affected thereby, and said illegal or invalid part, term or provision shall be deemed not to be a part of this Release.

12. **Entire Agreement/No Oral Modification**. This Release, together with the Employment Agreement as modified by this Release, contains the entire agreement between the parties hereto, and fully supersedes any and all prior agreements or understandings between the parties hereto pertaining to the subject matter hereof. There may be no modification of the terms of this Release except in writing signed by the parties hereto.

13. **Opportunity to Consult with Counsel**. The Employee acknowledges that she has had an opportunity to consult with and be represented by counsel of the Employee's choosing in the review of this Release, that she has been advised by the Company to do so, that the Employee is fully aware of the contents of the Release and of its legal effect, that the preceding paragraphs recite the sole consideration for this Release, and that the Employee enters into this Release freely, without duress or coercion, and based on the Employee's own judgment and wishes and not in reliance upon any representation or promise made by the Company, other than those contained herein.

14. **Choice of Law**. Except as otherwise stated herein, including, but not limited to Section 9 above,, this Release shall in all respects be interpreted, enforced and governed under the laws of the State of California. The language of all parts of this Release shall in all cases be construed as a whole, according to its fair meaning, and not strictly for or against any of the parties.

15. **Reformation**. In the event any part, term or provision herein is not enforceable including because its geographic scope, length or subject matter is determined to be excessive, then such part, term or provision shall be reformed to the minimum extent necessary to make such part, term or provision enforceable.

16. **Headings**. The headings of the Sections of this Agreement are provided for convenience only. They do not alter or limit, in any way, the text of any Section of this Agreement.

17. **Acceptance and Expiration**. The Employee has up to twenty-one (21) calendar days from the date she receives this document to consider and accept the terms of this Release, but may accept it at any time within those twenty-one (21) calendar days. The Employee agrees that changes to the terms or form of this Release, whether material or immaterial do not restart the running of the twenty-one (21) day period. After twenty-one (21) calendar days have passed, this offer will expire.

[signature page follows]

THE EMPLOYEE ACKNOWLEDGES BY SIGNING BELOW that (i) the Employee has not relied upon any representations, written or oral, not set forth in this Release; (ii) at the time the Employee was given this Release, the Employee was informed in writing by the Company that: (a) the Employee had at least twenty-one (21) calendar days in which to consider whether the Employee would sign the Release; (b) the Employee was advised to consult with an attorney before signing the Release; and (c) the Employee had seven (7) calendar days to revoke this Agreement after signing it; (iii) the Employee had an opportunity to consult with an attorney and either had such consultations or has freely decided to sign this Release without consulting an attorney; and (iv) the Employee executes this Release knowingly and voluntarily.

IN WITNESS WHEREOF, the parties hereto have executed this Release as of the dates set forth below.

The Employee   Health Net, Inc.

By: /s/ Angelee F. Bouchard   By: /s/ Karin D. Mayhew
Name: Angelee F. Bouchard   Name: Karin D. Mayhew
Title: Senior Vice President,
Organization Effectiveness

Dated: October 20, 2014   Dated: October 20, 2014

NOTE: Please return your signed waiver and release to:

Organization Effectiveness Unit
Attention: Karin Mayhew
21650 Oxnard Boulevard, Suite 2200
Woodland Hills, CA 91367

Exhibit 10.6

AMENDED AND RESTATED
EMPLOYMENT AGREEMENT

This AMENDED AND RESTATED EMPLOYMENT AGREEMENT (this "Agreement") is made and entered into as of February 25, 2015, by and between Health Net, Inc., a Delaware corporation (the "Company"), with its principal place of business located at 21650 Oxnard Street, Woodland Hills, California 91367, and Juanell Hefner ("Executive"). This Agreement amends and restates the Prior Agreement (as defined below) in its entirety.

RECITALS

WHEREAS, the Company and Executive previously entered into that certain Amended and Restated Employment Agreement dated February 7, 2012 (the "Prior Agreement"); and

WHEREAS, the Company and Executive desire to amend and restate the Prior Agreement on the terms and conditions set forth herein, and to supersede the Prior Agreement in all respects effective as of October 9, 2014 (the "Effective Date").

NOW, THEREFORE, in consideration of the following covenants, conditions and promises contained herein, and other good and valuable consideration, the Company and Executive hereby agree as follows:

1. Duties and Salary.

A. Duties. As of November 15, 2014, Executive's title is Chief Administration Officer, but may be changed at the discretion of the Company to a title that reflects a similarly situated senior executive position. Executive shall report directly to Jay Gellert, CEO and President of the Company, but Executive's reporting relationship may be changed from time to time at the discretion of the Company. Executive's duties and responsibilities as of February 21, 2015 include ensuring administrative oversight and coordination of Internal Audit, Communications, Information Technology, Customer Services and Transition Planning. However, the Company reserves the right to assign Executive other duties as needed and to change Executive's duties from time to time on reasonable notice, based on Executive's skills and the needs of the Company. In the event that Executive performs any such additional duties, Executive shall not be entitled to an increase in compensation beyond that specified in this Agreement. Unless otherwise determined by the Company, Executive shall perform her duties and conduct her business on behalf of the Company at various locations by telecommuting. The Company may provide temporary housing or lodging for her to accommodate completion of assignments in particular locations, subject to Company policies.

B. Salary. As of February 21, 2015, Executive will be paid a base salary at the annual rate of $546,351, which salary will be paid on a pro-rated bi-weekly basis, less applicable withholdings ("Base Salary"), covering all hours worked. Generally, Executive's Base Salary will be reviewed annually, but the Company reserves the right to change Executive's compensation from time-to-time. Pursuant to the charter of the Compensation Committee of the Company's Board of Directors (the "Committee"), any adjustment to Executive's compensation must be made with the approval of the Committee and, in the event that Executive constitutes one of the top two (2) highest paid executive officers of the Company, with the ratification of the Company's Board of Directors.

A. Disclosure of Personal Compensation Information. As an "executive officer" of the Company (as such term is defined in the rules and regulations of the Securities and Exchange Commission ("SEC")), information regarding Executive's employment arrangements with the Company, including, among other things, the terms of this Agreement and any stock option agreement, restricted stock agreement, restricted stock unit agreement, performance share agreement and/or severance agreement Executive enters into with the Company from time to time (collectively, "Personal Compensation Information"), may be disclosed in filings with the SEC, the New York Stock Exchange ("NYSE") and/or other regulatory organizations upon the occurrence of certain triggering events. Such triggering events include, but are not limited to, the execution of this Agreement and any amendments thereto, changes in Executive's Base Salary, any annual incentive payment (whether in the form of cash or equity) awarded to Executive (in the past or after the date hereof), and the establishment of performance goals under the Company's incentive plans. Executive's execution of this Agreement will serve as Executive's acknowledgement that Executive's Personal Compensation Information may be publicly disclosed from time to time in filings with the SEC, NYSE or otherwise as necessary.

2. Adjustments and Changes in Employment Status. Executive understands that the Company reserves the right to make personnel decisions regarding Executive's employment, including, but not limited to, decisions regarding any promotion, salary adjustment, transfer or disciplinary action, up to and including Termination (as defined below), consistent with the needs of the business of the Company.

For purposes of this Agreement, the capitalized terms "Termination" and "Terminate," shall mean Executive's Separation from Service (as defined below) from the Company. A "Separation from Service" with respect to Executive shall mean a "separation from service," as defined in Treasury Regulation Section 1.409A-1(h) or any regulation that supersedes such regulation.

3. Protection of Proprietary and Confidential Information. Executive agrees that Executive's employment creates a relationship of confidence and trust with the Company with respect to Proprietary and Confidential Information (as defined below) of the Company learned by Executive during Executive's employment.

A. Executive agrees not to directly or indirectly use or disclose any of the Proprietary and Confidential Information of the Company or any of its affiliates at any time except in connection with the services Executive provides to such entities. "Proprietary and Confidential Information" shall mean trade secrets, confidential knowledge, data or any other proprietary or confidential information of the Company or any of its affiliates, or of any customers, members, employees or directors of any of such entities, but shall not include any information that (i) was publicly known and made generally available in the public domain prior to the time of disclosure to Executive by the Company or (ii) becomes publicly known and made generally available after disclosure to Executive by the Company other than as a result of a disclosure by Executive in violation of this Agreement. By way of illustration but not limitation, "Proprietary and Confidential Information" includes: (i) trade secrets, documents, memoranda, reports, files, correspondence, lists and other written and graphic records affecting or relating to any such entity's business; (ii) confidential marketing information including without limitation marketing strategies, customer and client names and requirements, services, prices, margins and costs; (iii) confidential financial information; (iv) personnel information (including without limitation employee compensation); and (v) other confidential business information.

B. Executive further agrees that at all times during Executive's employment and thereafter, Executive will keep in confidence and trust all Proprietary and Confidential Information, and that Executive will not use or disclose any Proprietary and Confidential Information or anything related to such information without the written consent of the Company, except as may be necessary in the ordinary course of performing Executive's duties to the Company.

C. All Company property, including, but not limited to, Proprietary and Confidential Information, documents, data, records, apparatus, equipment and other physical property, whether or not pertaining to Proprietary and Confidential Information, provided to Executive by the Company or any of its affiliates or produced by Executive or others in connection with Executive's providing services to the Company or any of its affiliates shall be and remain the sole property of the Company or its affiliates (as the case may be) and shall be returned promptly to such appropriate entity as and when requested by such entity. Executive shall return and deliver all such property upon termination of Executive's employment, and Executive may not take any such property or any reproduction of such property upon such termination.

D. Executive recognizes that the Company and its affiliates have received and in the future will receive information from third parties which is private, proprietary or confidential information subject to a duty on such entity's part to maintain the confidentiality of such information and to use it only for certain limited purposes. Executive agrees that during Executive's employment, and thereafter, Executive owes such entities and such third parties a duty to hold all such private, proprietary or confidential information received from third parties in the strictest confidence and not to disclose it, except as necessary in carrying out Executive's work for such entities consistent with such entities' agreements with such third parties, and not to use it for the benefit of anyone other than for such entities or such third parties consistent with such entities' agreements with such third parties.

E. Executive's obligations under this Section 3 shall continue after the Termination of Executive's employment and any breach of this Section 3 shall be a material breach of this Agreement.

4. Physical Exam. Beginning in 2012, Executive shall be required, on an annual basis, to undergo a physical examination and to send evidence that Executive has undergone such exam (but in no case the results of such exam) to the Senior Vice President of Organization Effectiveness. The Company shall reimburse Executive for any out-of-pocket expenses relating to the physical examination that are not otherwise covered by Executive's health insurance plan.

5. Representations and Warranties of Executive.

A. No Violation; No Conflicts. Executive represents and warrants to the Company that the entering into of this Agreement and Executive's performance of Executive's duties hereunder, will not violate any agreements with, or trade secrets of, any other person or entity. Executive further represents and warrants that Executive does not have any relationship or commitment to any other person or entity that might be in conflict with Executive's obligations to the Company under this Agreement, including but not limited to outside employment, sales broker relationships, investments or business activities. Executive understands and agrees that while employed by the Company Executive is expected to refrain from engaging in any outside activities that might be in conflict with the business interests of the Company. In addition, Executive represents and warrants to the Company that Executive has not shared with or disclosed to, and will not share with or disclose to, the Company any proprietary or confidential information of Executive's previous employers or any other third party.

B. Legal Proceedings. Executive represents and warrants to the Company that Executive has not been arrested, indicted, convicted or otherwise involved in any criminal or civil action or legal matter that could affect Executive's ability to perform Executive's duties hereunder or that may have a negative impact on the Company, its reputation or its operations. Executive agrees, to the extent permitted by applicable law, to notify the Company's Senior Vice President of Organization Effectiveness immediately in the event that Executive becomes party to any criminal or civil action or other legal matter in the future that could have an affect on the foregoing representation.

6. Executive Benefits.

A. Employee Benefit Programs. Executive shall be eligible to participate in the Company's various employee benefit programs and plans in place from time to time in accordance with their terms, as long as Executive remains employed by the Company and Executive meets the applicable participation requirements. These benefit programs and plans currently include paid time off ("PTO"), holidays, group medical, dental, vision, term life, and short and long term disability insurance and participation in the Company's 401(k) plan, tuition reimbursement plan and deferred compensation plan. The Company or its subsidiaries or affiliates may modify, terminate or amend any benefit or plan in its discretion, retroactively or prospectively, subject only to applicable law.

B. Required Insurance. Executive will be covered by workers' compensation insurance and state disability insurance, as required by state law.

C. Fringe Benefits. Executive will be entitled to such fringe benefits and perquisites as are provided by the Company from time to time, in accordance with the Company's policies, practices and procedures, and shall receive such additional fringe benefits and perquisites as the Company may, in its discretion, from time-to-time provide. Without limiting the generality of the foregoing, Executive will be entitled to (i) be reimbursed up to the amount of $5,000 per year for documented costs incurred for personal financial counseling services provided to Executive, including tax preparation, and (ii) receive a $1,000 per month car allowance (a grandfathered benefit), in each case, as long as Executive remains employed by the Company.

A. Incentive Bonus. Executive will be eligible to participate in the Health Net, Inc. Management Incentive Plan, or such other Company bonus plan that may be in effect from time to time, in accordance with the terms of such plan, which provides Executive with a target bonus for each plan year equal to 80% of Executive's Base Salary as additional compensation according to the terms of such plan. The actual bonus payment will range from 0% to 200% of target depending upon the actual results achieved. It is understood that the Committee and the Company will award bonus amounts, if any, as it deems appropriate consistent with the MIP or such other bonus plan that may be in effect from time to time.

B. Expenses. Subject to and in accordance with the Company's written policies for business and travel expenses, Executive will receive reimbursement for all business travel and other out-of-pocket expenses reasonably incurred by Executive in the performance of Executive's duties pursuant to this Agreement.

7. Equity Grants; Stock Ownership Requirement.

A. Future Equity Grants. Any future equity grants made to Executive will be granted under one of the Company's Long-Term Incentive Plans, and will be subject to the terms of such plan and of the agreement executed in connection with such grant. Any future equity grants to Executive will be made at the discretion of the Committee.

B. Company Stock Ownership Requirement. In accordance with the Executive Officer Stock Ownership Policy adopted by the Board of Directors of the Company, as may be amended from time to time (the "Executive Stock Ownership Policy"), Executive is currently required to own "Qualifying Shareholdings" (as defined in the Executive Stock Ownership Policy) having a value of one time (1x) Executive's Base Salary in effect from time to time pursuant to this Agreement (the "Stock Ownership Requirement"). The number of Qualifying Shareholdings Executive is required to own will be calculated based on the average NYSE closing price per share of the Company's Common Stock (as adjusted for stock splits and similar changes to the Common Stock) for the most recently completed fiscal year of the Company.

Using Executive's Base Salary as of February 21, 2015, which was $546,351 and a stock price of $41.04, which was the average closing price per share of the Company's Common Stock for the fiscal year ended December 31, 2014, Executive's Stock Ownership Requirement as of February 21, 2015 was 13,313 shares ("Target Amount"). The Target Amount is subject to change from time to time based on (1) changes in the average closing price per share of the Company's Common Stock on an annual basis, (2) any changes in Executive's Base Salary made pursuant to and in accordance with Section 1(B) of this Agreement, and (3) any changes under the terms of the Executive Stock Ownership Policy.

Under the Executive Stock Ownership Policy as currently in effect, to the extent that Executive has not achieved the Stock Ownership Requirement, Executive must hold 75% of all "net settled shares" received from the vesting, delivery or exercise of equity awards granted under the Company's equity award (including long-term incentive) plans, as such term is defined in the Executive Stock Ownership Policy.

The Committee expects that Executive will make reasonable progress toward Executive's Stock Ownership Requirement. Executive will be notified on an annual basis of any changes in Executive's Target Amount.

8. Term of Employment. Executive's employment with the Company is at the mutual consent of Executive and the Company. Nothing in this Agreement is intended to guarantee Executive's continuing employment with the Company or employment for any specific length of time. Accordingly, either Executive or the Company may terminate the employment relationship at any time and for any reason whatsoever (or for no reason), subject to certain notice requirements, to the extent applicable, as set forth herein. Upon Termination of Executive's employment for any reason, in addition to any other payments that may be payable to Executive hereunder, Executive (or Executive's beneficiaries or estate) shall be paid (in each case to the extent not theretofore paid) within thirty (30) days following Executive's date of Termination (or such shorter period that may be required by applicable law): (a) Executive's annual Base Salary through such Termination date, (b) accrued but unused PTO, (c) reimbursable expenses incurred by Executive prior to the Termination date and (d) amounts to which Executive may be entitled through such Termination date under any other compensatory plan, arrangement or program payment in accordance with the terms thereunder. This Agreement constitutes a final and fully binding integrated agreement with respect to the at-will nature of the employment relationship.

9. Termination of Employment/Severance Pay.

A. Termination Without Cause Not Following Change in Control. If Executive's employment is Terminated by the Company without "Cause" (as defined in Section 9(D) below) at any time that is not within two (2) years after a "Change in Control" (as defined below) of Health Net, Inc., Executive will be entitled to receive, within thirty (30) days following the Termination of Executive's employment, provided that Executive signs and delivers prior to the expiration of such (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) a lump sum cash payment equal to twelve (12) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, and (ii) the continuation, under COBRA, of Executive's medical, dental and vision benefits (as maintained for Executive's benefit immediately prior to the date of Executive's Termination) (the "Benefits") for Executive and Executive's dependents for a period of twelve (12) months following the effective date of Executive's Termination, with premium payments paid by the Company on Executive's behalf as they become due, provided, that Executive properly elects to continue those benefits under COBRA.

For purposes of this Agreement, "Change in Control" is defined as any of the following which occurs subsequent to the Effective Date:

(i) Any person (as such term is defined under Section 13(d)(3) of the Securities Exchange Act of 1934, as amended (the "Exchange Act")), corporation or other entity (other than Health Net, Inc. or any of its subsidiaries, or any employee benefit plan sponsored by Health Net, Inc. or any of its subsidiaries) is or becomes the beneficial owner (as such term is defined in Rule 13d-3 under the Exchange Act) of securities of Health Net, Inc. representing twenty percent (20%) or more of the combined voting power of the outstanding securities of Health Net, Inc. which ordinarily (and apart from rights accruing under special circumstances) have the right to vote in the election of directors (calculated as provided in paragraph (d) of such Rule 13d-3 in the case of rights to acquire Health Net, Inc.'s securities) (the "Securities");

(ii) As a result of a tender offer, merger, sale of assets or other major transaction, the persons who are directors of Health Net, Inc. immediately prior to such transaction cease to constitute a majority of the Board of Directors of Health Net, Inc. (or any successor corporations) immediately after such transaction;

(iii) Health Net, Inc. is merged or consolidated with any other person, firm, corporation or other entity and, as a result, the shareholders of Health Net, Inc., as determined immediately before such transaction, own less than eighty percent (80%) of the outstanding Securities of the surviving or resulting entity immediately after such transaction:

(iv) A tender offer or exchange offer is made and consummated for the ownership of twenty percent (20%) or more of the outstanding Securities of Health Net, Inc.;

(v) Health Net, Inc. transfers substantially all of its assets to another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc.; or

(vi) Health Net, Inc. enters into a management agreement with another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc. and such management agreement extends hiring and firing authority over Executive to an individual or organization other than Health Net, Inc.

B. Termination Without Cause or For Good Reason Following Change in Control. If at any time within two (2) years after a Change in Control of Health Net, Inc. Executive's employment is Terminated by the Company without Cause or Executive Terminates Executive's employment for "Good Reason" (as defined below) (by giving the Company at least fourteen (14) days prior written notice of the effective date of Termination), then Executive will be entitled to receive, within thirty (30) days following the Termination of Executive's employment, provided that Executive signs and delivers prior to the expiration of such thirty (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) a lump sum payment equal to twenty-four (24) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, and (ii) the continuation of Executive's Benefits for six (6) months following Executive's date of Termination, and (iii) and after expiration of such six (6) months Benefits continuation period, the continuation, under COBRA, of Benefits for Executive and Executive's dependents for an additional period of eighteen (18) months following the effective date of Executive's Termination with premium payments made by the Company on Executive's behalf, provided, that Executive properly elects to continue those benefits under COBRA, and provided, further, that in the event the Company requests, in writing, prior to such voluntary Termination by Executive for Good Reason that Executive continue in the employ of the Company for a period of time up to 90 days following such Change in Control, then Executive shall forfeit such severance allowance if Executive voluntarily leaves the employ of the Company prior to the expiration of such period of time.

For purposes of this Agreement, the term "Good Reason" means any of the following which occurs, without Executive's consent, subsequent to the effective date of a Change in Control as defined above:

(i) A substantial reduction in the scope of Executive's authority, duties or responsibilities with the Company, except in connection with the Termination of Executive's employment for Disability (as defined below), normal retirement or Cause or by Executive voluntarily other than for Good Reason;

(ii) A material reduction by the Company in Executive's base compensation (*i.e.*, Executive's Base Salary and/or target annual bonus) as in effect immediately prior to any such reduction;

(iii) A relocation of Executive to a work location more than fifty (50) miles from Executive's work location immediately prior to such proposed relocation; provided that such proposed relocation results in a materially greater commute for Executive based on Executive's residence immediately prior to such relocation; or

(iv) The failure of the Company to obtain an assumption agreement from any successor contemplated under Section 12 of this Agreement;

<u>provided</u>, <u>however</u>, that (a) Executive provides written notice to the Company of the existence of the condition described above within ninety (90) days of the initial existence of the condition, (b) the Company fails to cure such condition within thirty (30) days after receipt of such written notice, and (c) the date of Executive's Termination occurs no later than seventy-five (75) days after the initial occurrence of the event constituting Good Reason, in accordance with Treasury Regulation Section 1.409A-1(n)(2)(ii).

C. <u>Voluntary Termination</u>. Notwithstanding anything to the contrary in this Agreement, whether express or implied, Executive may at any time Terminate Executive's employment for any reason by giving the Company fourteen (14) days prior written notice of the effective date of Termination. In the event that Executive voluntarily Terminates employment with the Company (except for Good Reason within two (2) years after a Change in Control of Health Net, Inc., as described in Section 9 (B) hereof), then Executive shall not be eligible to receive any payments or continuation of Benefits set forth in this Section 9.

D. <u>Termination by the Company for Cause.</u> The Company may Terminate Executive's employment for "Cause" at any time with or without advance notice. In the event of such Termination, Executive will not be eligible to receive any of the payments set forth in Section 9(A) or 9(B) above. For purposes of this Agreement, a Termination for "Cause" is defined as: (i) an act of dishonesty causing harm to the Company or any of its affiliates, (ii) the material breach of either the Company's Code of Business Conduct and Ethics (the "Code of Conduct") or any policy or procedure developed and published by the Company regarding compliance or ethics related to the Code of Conduct, (iii) habitual drunkenness or narcotic drug addiction, (iv) conviction of, or entry by Executive of a guilty or no contest plea to, the commission of a felony or a misdemeanor involving moral turpitude, (v) willful refusal to perform or gross neglect of the duties assigned to Executive, (vi) the willful breach of any law that, directly or indirectly, affects the Company or any of its affiliates, (vii) a material breach by Executive following a Change in Control of those duties and responsibilities of Executive that do not differ in any material respect from Executive's duties and responsibilities during the 90-day period immediately prior to such Change in Control (other than as a result of incapacity due to physical or mental illness) which is demonstrably willful and deliberate on Executive's part, which is committed in bad faith or without reasonable belief that such breach is in the best interests of the Company or any of its affiliates and which is not remedied in a reasonable period of time after receipt of written notice from the Company specifying such breach, or (viii) breach of Executive's obligations hereunder (or under any Company policy) to protect the proprietary and confidential information of the Company or any of its affiliates.

E. Termination Due to Death or Disability. In the event that Executive's employment is Terminated at any time due to Executive's death or "Disability" (as defined below), Executive (or Executive's beneficiaries or estate) shall be entitled to receive, provided Executive (or Executive's beneficiaries or estate, as applicable) signs a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) continuation of Executive's Benefits for a period of twelve (12) months from the date of Termination and (ii) a lump sum payment equal to twelve (12) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, to be paid within thirty (30) days following Executive's Termination of employment. For purposes of this Agreement, a Termination for "Disability" shall mean a Termination of Executive's employment due to Executive's absence from Executive's duties with the Company on a full-time basis for at least 180 consecutive days as a result of Executive's incapacity due to physical or mental illness which is determined to be total and permanent by a physician selected by the Company or its insurers.

10. Withholding. All payments required to be made by the Company hereunder to Executive or Executive's estate or beneficiaries shall be subject to the withholding of such amounts relating to taxes as the Company may reasonably determine should be withheld pursuant to any applicable law or regulation.

11. Restrictive Covenants.

A. Non-Competition. Executive hereby agrees that, during (i) the six (6)-month period following a Termination of Executive's employment with the Company that entitles Executive to receive severance benefits under this Agreement or a written agreement with or policy of the Company or (ii) the twelve (12)-month period following a Termination of Executive's employment with the Company that does not entitle Executive to receive such severance benefits (the period referred to in either clause (i) or (ii), the "Restricted Period"), Executive shall not undertake any employment or activity (including, but not limited to, consulting services) with a Competitor (as defined below) in any geographic area in which the Company or any of its affiliates operate (the "Market Area"), where the loyal and complete fulfillment of the duties of the competitive employment or activity would call upon Executive to reveal, to make judgments on or otherwise use or disclose any confidential business information or trade secrets of the business of the Company or any of its affiliates to which Executive had access during Executive's employment with the Company. For purposes of this Section, "Competitor" shall refer to any health maintenance organization or insurance company that provides managed health care or related services similar to those provided by the Company or any of its affiliates.

B. Non-Solicitation. In addition, Executive agrees that, during the applicable Restricted Period following Termination of Executive's employment with the Company, Executive shall not, directly or indirectly, (i) solicit, interfere with, hire, offer to hire or induce any person, who is or was an employee of the Company or any of its affiliates at the time of such solicitation, interference, hiring, offering to hire or inducement, to discontinue his/her relationship with the Company or any of its affiliates or to accept employment by, or enter into a business relationship with, Executive or any other entity or person or (ii) solicit, interfere with or otherwise contact any customer or client of the Company or any of its affiliates.

C. Modification of Restrictions. It is hereby further agreed that if any court of competent jurisdiction shall determine that the restrictions imposed in this Section 11 are unreasonable (including, but not limited to, the definition of Market Area or Competitor or the time period during which this provision is applicable), the parties hereto hereby agree to any restrictions that such court would find to be reasonable under the circumstances.

D. Injunction Rights. Executive also acknowledges that the services to be rendered by Executive to the Company are of a special and unique character, which gives this Agreement a peculiar value to the Company or any of its affiliates, the loss of which may not be reasonably or adequately compensated for by damages in an action at law, and that a material breach or threatened breach by Executive of any of the provisions contained in this Section 11 will cause the Company or any of its affiliates irreparable injury. Executive therefore agrees that the Company may be entitled, in addition to the remedies set forth above in this Section 11 and any other right or remedy, to a temporary, preliminary and permanent injunction, without the necessity of proving the inadequacy of monetary damages or the posting of any bond or security, enjoining or restraining Executive from any such violation or threatened violations.

12. Successors; Binding Agreement.

A. Survival Following Merger, Consolidation or Asset Transfer. This Agreement shall not be terminated by any merger or consolidation of the Company whereby the Company is or is not the surviving or resulting corporation or as a result of any transfer of all or substantially all of the assets of the Company. In the event of any such merger, consolidation or transfer of assets, the provisions of this Agreement shall be binding upon the surviving or resulting corporation or the person or entity to which such assets are transferred.

B. Survivor's Assumption of Agreement. The Company agrees that concurrently with any merger, consolidation or transfer of assets referred to in this Section 12, it will cause any successor or transferee to unconditionally assume, by written instrument delivered to Executive (or Executive's beneficiary or estate), all of the obligations of the Company hereunder. Failure of the Company to obtain such assumption prior to the effectiveness of any such merger, consolidation or transfer of assets shall entitle Executive to compensation and other benefits from the Company in the same amount and on the same terms as Executive would be entitled hereunder if Executive's employment were Terminated without Cause. For purposes of implementing the foregoing, the date on which any such merger, consolidation or transfer becomes effective shall be deemed the date of Termination.

C. Enforceability. This Agreement shall inure to the benefit of and be enforceable by Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees. If Executive shall die while any amounts would be payable to Executive hereunder had Executive continued to live, all such amounts, unless otherwise provided herein, shall be paid in accordance with the terms of this Agreement to such person or persons appointed in writing by Executive to receive such amounts or, if no person is so appointed, to Executive's estate.

13. Limitation on Payments.

A. Notwithstanding any other provisions of this Agreement, in the event that any payment or benefit received or to be received by Executive (including any payment or benefit received in connection with a Change in Control or the termination of Executive's employment, whether pursuant to the terms of this Agreement or any other plan, arrangement or agreement) (all such payments and benefits, including the payments and benefits under Section 9 hereof, being hereinafter referred to as the "Total Payments") would be subject (in whole or part), to the excise tax imposed under Section 4999 of the Internal Revenue Code of 1986, as amended (the "Code") (the "Excise Tax"), then, after taking into account any reduction in the Total Payments provided by reason of Section 280G of the Code in such other plan, arrangement or agreement, the cash severance payments shall first be reduced, and the non-cash severance payments shall thereafter be reduced, to the extent necessary so that no portion of the Total Payments is subject to the Excise Tax, but only if (i) the net amount of such Total Payments, as so reduced (and after subtracting the net amount of federal, state and local income taxes on such reduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such reduced Total Payments), is greater than or equal to (ii) the net amount of such Total Payments without such reduction (but after subtracting the net amount of federal, state and local income taxes on such Total Payments and the amount of Excise Tax to which Executive would be subject in respect of such unreduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such unreduced Total Payments). The Total Payments shall be reduced by the Company in its reasonable discretion in the following order: (A) reduction of any cash severance payments otherwise payable to Executive that are exempt from Section 409A (as defined below), (B) reduction of any other cash payments or benefits otherwise payable to Executive that are exempt from Section 409A, but excluding any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A, (C) reduction of any other payments or benefits otherwise payable to Executive on a pro-rata basis or such other manner that complies with Section 409A, but excluding any payments attributable to the acceleration of vesting and payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A, and (D) reduction of any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A.

B. For purposes of determining whether and the extent to which the Total Payments will be subject to the Excise Tax, (i) no portion of the Total Payments the receipt or enjoyment of which Executive shall have waived at such time and in such manner as not to constitute a "payment" within the meaning of Section 280G(b) of the Code shall be taken into account, (ii) no portion of the Total Payments shall be taken into account which, in the written opinion of independent auditors of nationally recognized standing ("Independent Advisors") selected by the Company, does not constitute a "parachute payment" within the meaning of Section 280G(b)(2) of the Code (including by reason of Section 280G(b)(4)(A) of the Code) and, in calculating the Excise Tax, no portion of such Total Payments shall be taken into account which, in the opinion of Independent Advisors, constitutes reasonable compensation for services actually rendered, within the meaning of Section 280G(b)(4)(B) of the Code, in excess of the "base amount" (as defined in Section 280G(b)(3) of the Code) allocable to such reasonable compensation, and (iii) the value of any non-cash benefit or any deferred payment or benefit included in the Total Payments shall be determined by the Independent Advisors in accordance with the principles of Sections 280G(d)(3) and (4) of the Code.

14. <u>Section 409A of the Internal Revenue Code</u>. It is the intention of the Company and Executive that this Agreement not result in unfavorable tax consequences to Executive under Section 409A of the Code, and the Treasury Regulations and Internal Revenue Service guidance promulgated thereunder ("Section 409A") and the Agreement shall be interpreted, construed and administered as to so comply with, or be exempt from, Section 409A. Notwithstanding anything to the contrary herein, the Company and Executive agree to the provisions set forth in this Section 14 in order to comply with, or be exempt from, the requirements of Section 409A.

A. If Executive is a "specified employee" (as determined under the Company's Specified Employee Policy as in effect from time to time, or, in the absence of such policy, within the meaning of Section 409A) with respect to the Company, any non-exempt non-qualified deferred compensation that is subject to Section 409A and otherwise payable to or in respect of Executive in connection with Executive's Separation from Service pursuant to this Agreement shall be delayed until the earlier of (i) the expiration of six (6) months measured from the date of Executive's Separation from Service, or (ii) the date of Executive's death. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

B. All incentive bonus payments described in Section 6(D) shall be paid to Executive, to the extent earned, in no event later than the last day of the "applicable 2-1/2 month period", as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

C. With respect to the Company's reimbursement obligations under Sections 6(C) and 6(E) hereof and the provision of Benefits to Executive, (i) in no event shall any such reimbursements or in-kind benefits be made or provided later than the last day of Executive's taxable year following the taxable year in which the fee or expense was incurred, (ii) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during Executive's taxable year may not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year of Executive, and (iii) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit, in accordance with Treasury Regulation Section 1.409A-3(i)(1)(iv).

D. The Company and Executive agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by Executive due to any failure to comply with Section 409A. To the extent payments and benefits under this Agreement are subject to Section 409A, and such payments and benefits do not so comply, the Company shall amend this Agreement, or take such other actions as the Company deems reasonably necessary or appropriate, to comply with Section 409A. If any provision of the Agreement would cause such payments and benefits to fail to so comply, such provision shall not be effective and shall be null and void with respect to such payments or benefits, and such provision shall otherwise remain in full force and effect.

15. Company Policies. Executive's employment with the Company is subject to the terms and conditions contained in the Company's Associate Policies, including those located on HR Link, which can be accessed through the Company's intranet site, as in effect from time to time (the "Associate Policies"), the content of which is incorporated by reference herein. Executive shall be required to read, understand and comply with the Associate Policies.

16. Compensation Recovery (Clawback). Notwithstanding anything in this Agreement to the contrary, any compensation payable to Executive under this Agreement that constitutes "Incentive Compensation" (as such term is defined under the Company's Compensation Recovery Policy, as such policy may be amended from time to time (the "Compensation Recovery Policy")) shall be subject to the terms and conditions of the Compensation Recovery Policy.

17. Severability. If any term of this Agreement is held to be invalid, void or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected and the parties shall use their best efforts to find an alternative way to achieve the same result.

18. Integrated Agreement. This Agreement supersedes any prior agreements, representations or promises of any kind, whether written, oral, express or implied between the parties hereto with respect to the subject matters herein, including the Prior Agreement. It constitutes the full, complete and exclusive agreement between Executive and the Company with respect to the subject matters herein. This Agreement cannot be changed unless in writing, signed by Executive and a duly authorized officer of the Company and approved by the Board of Directors of the Company (or the Committee or its delegate, if permitted by the Committee's charter). The Company acknowledges and agrees that nothing contained herein shall be deemed to supercede, amend or otherwise modify the terms of the Indemnification Agreement dated January 11, 2012 between Executive and the Company.

19. Waiver. No waiver of any default hereunder shall operate as a waiver of any subsequent default. Failure by either party to enforce any of the terms or conditions of this Agreement, for any length of time or from time to time, shall not be deemed to waive or decrease the rights of such party to insist thereafter upon strict performance by the other party.

20. Notices. All notices and communications required or permitted hereunder shall be in writing and shall be deemed given (a) if delivered personally, (b) upon confirmation of receipt by the sender after being sent by electronic mail, (c) one (1) business day after being sent by Federal Express or a similar commercial overnight service, or (d) three (3) business days after being mailed by registered or certified mail, return receipt requested, prepaid and addressed to the following addresses, or at such other addresses as the parties may designate by written notice in the manner aforesaid:

If to the Company: Health Net, Inc.
21650 Oxnard Street, 22nd Floor
Woodland Hills, CA 91367
Attention: General Counsel

If to Executive: Juanell Hefner
c/o Health Net, Inc.
21650 Oxnard Street
Woodland Hills, CA 91367

21. Governing Law. The interpretation, construction and performance of this Agreement shall be governed by and construed and enforced in accordance with the internal laws of the State of Delaware without regard to the principle of conflicts of laws. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provisions of this Agreement, which other provisions shall remain in full force and effect.

22. Survival and Enforcement. Sections 3, 8, 9, 11, 12, 13, 14 and 16 of this Agreement and any rights and remedies arising out of this Agreement shall survive and continue in full force and effect in accordance with the respective terms thereof, notwithstanding any termination of this Agreement or a Termination of Executive's employment. The parties agree that the Company would be damaged irreparably in the event any provision of Sections 3, 11 and 12 of this Agreement were not performed in accordance with its terms or were otherwise breached and that money damages would be an inadequate remedy for any such nonperformance or breach. Therefore, the Company or its successors or assigns shall be entitled in addition to other rights and remedies existing in their favor, to an injunction or injunctions to prevent any breach or threatened breach of any of such provisions and to enforce such provisions specifically (without posting a bond or other security).

23. Acknowledgement. Executive acknowledges that Executive has had the opportunity to discuss the content of this Agreement with and obtain advice from Executive's attorney, have had sufficient time to and have carefully read and fully understood all of the provisions of this Agreement, and Executive is knowingly and voluntarily entering into this Agreement. Executive further acknowledges that Executive is obligated to become familiar with and comply at all times with all written policies of the Company.

[Signature Page to Follow]

Exhibit 10.6

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth above.

Executive Health Net, Inc.

By: /s/ Juanell Hefner By: /s/ Jay Gellert
Name: Juanell Hefner Name: Jay Gellert
Title: Chief Administration Officer Title: Chief Executive Officer and President

cc: Angelee F. Bouchard
Karin D. Mayhew
Debbie J. Colia / Juanell Hefner Personnel File

Exhibit 10.6

EXHIBIT A

FORM OF WAIVER AND RELEASE OF CLAIMS

This WAIVER AND RELEASE OF CLAIMS (this “Release” or “Agreement”) is made and entered into by and between Health Net, Inc. and its affiliates and subsidiaries (hereinafter referred to as the “Company”) and____________ (hereinafter referred to as the “Employee”).

WHEREAS, the Company and Employee are entering into this Release as a condition to Employee’s receipt of severance pay upon his or her termination of employment with the Company.

NOW, THEREFORE, the Company and Employee agree as follows:

1. **Termination Date.** Employee’s employment with the Company shall terminate on ______________ (the “Termination Date”). Following termination of employment, Employee shall not represent to anyone that he or she is an employee of the Company and shall not say or do anything purporting to bind the Company. For purposes of this Agreement, Employee will be entitled to receive the severance payment and benefits set forth under Section 2 hereof only to the extent Employee’s termination of employment constitutes a “separation from service,” as defined in Treasury Regulation Section 1.409A-1(h), and, in the event that Employee’s “separation from service” occurs on a date other than the date set forth above, the “Termination Date” shall mean the date of Employee’s “separation from service.”

2. **Severance Benefits.** Provided that Employee signs and delivers this Agreement to the Company on or before the twenty-first (21st) day after Employee’s receipt of this Agreement and does not revoke his/her acceptance within seven (7) days after signing this Agreement, the Company will provide Employee with the following benefits and payments, subject to the terms and conditions set forth in this Release:

   a. Employee shall be entitled to receive a lump sum severance payment under the terms of Employee’s employment agreement or an applicable Company severance policy (as in effect from time to time) in the amount of $______ (which is equal to ____ months of Employee’s monthly base salary in effect as of the date set forth in Section 1), subject to withholding for payroll taxes and applicable deductions. The severance payment will be made on the regular Company payday for the first payroll period beginning after the Effective Date as defined in Section 4(d)(vi), and in no event later than March 15 following the calendar year in which the Termination Date occurs.

   In the event that the Company rehires Employee and the number of months between Employee’s Termination Date and the date of his or her re-hire, if any, is less than the number of months of Employee’s monthly base salary that was taken into account to calculate his or her lump sum severance payment, then the Employee shall repay to the Company an amount equal to the amount of his or her severance payment multiplied by a fraction, the numerator of which is the number of months on which the severance payment was based, minus the number of months (any partial month will be prorated) during which the Employee was unemployed by the Company, and the denominator of which is the number of months on which the severance payment was based (e.g. if an employee receives three months of severance pay and is re-hired by the Company two months after his or her Termination Date, he or she will be required to repay to the Company an amount equal to one month of severance pay.) In addition, upon re-hire the COBRA premium benefits set forth in Section 2(b) will cease when Employee becomes eligible as an employee for benefits under the Company's group health, vision and dental plans.

In further consideration for the Employee's acceptance of this Agreement, the Company will provide outplacement services to the Employee rendered by Lee Hecht Harrison per the Company's outplacement service program in effect as of the date of this Agreement. The Employee must enroll in the outplacement service program with Lee Hecht Harrison within sixty (60) days of the Employee's Termination Date in order to be eligible to receive these outplacement service benefits. To the greatest extent applicable, such outplacement services shall be provided in a manner that is exempt from Section 409A of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations and Internal Revenue Service guidance thereunder ("Section 409A") in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(A). In the event that the outplacement services constitute nonqualified deferred compensation subject to Section 409A of the Code, the outplacement services shall be provided in a manner that complies with Section 409A of the Code and the provisions of Section 19 hereof.

b. Effective as of the first day of the month immediately following the month in which the Termination Date occurs, Employee and Employee's spouse/life partner and dependents who are covered under the Company's employee welfare benefit plan which is a group health plan immediately prior to the Termination Date shall be eligible to elect to continue coverage under such plan, as required under and in accordance with Part VI ("COBRA") of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). If the appropriate COBRA election forms are completed, signed and returned by the applicable deadlines established by the Company, the Company shall pay on the Employee's behalf the full cost of the COBRA coverage for group health plan and dental and vision benefits as employee had in effect immediately prior to the Termination Date under such plan until the earlier of (i) the end of ______ months from the Termination Date and (ii) the date Employee becomes eligible for coverage under a plan of another employer. If the group health, dental or vision benefit elected by Employee is replaced or becomes unavailable, the Company will pay for coverage under the replacement benefit or, if a benefit is not replaced, the most similar plan remaining in effect. If, upon the termination of the Company's payment of such COBRA coverage, Employee continues to be entitled under federal law to receive COBRA coverage, then any such coverage shall be available to Employee, solely at Employee's expense, at the full COBRA coverage rates then in effect. COBRA election forms will be mailed to Employee's home address under separate cover. To the greatest extent applicable, such continued health coverage shall be provided in a manner that is exempt from Section 409A in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(B).

3. **Acknowledgements**.

a. Employee acknowledges and agrees that the payments and benefits set forth in Sections 2(a) and (b) above are payments and benefits to which Employee is not otherwise entitled, and Employee understands that if he or she does not sign this Release, or if he or she revokes acceptance of this Release, Employee shall not be entitled to these payments and benefits.

b. By signing below, Employee confirms and agrees that as of the Termination Date, Employee has been paid, or will be paid in his or her final regular paycheck (subject to withholding for taxes and applicable deductions), all accrued salary, unused accrued Paid Time Off, and other similar payroll related benefits and compensation due the Employee as of the Termination Date by virtue of his or her employment, in keeping with the Company's policy and practice. Employee further acknowledges that no other compensation or wages are due and owing to Employee, and no further Paid Time Off or other benefits will accrue after the Termination Date.

c. Employee's participation in all Company employee benefit plans as an active employee shall cease on the Termination Date, and Employee shall not be eligible to make contributions to or to receive additional Company contributions under the Health Net, Inc. 401(k) Associate Savings Plan, (the "401(k) Plan") (other than any "supplemental Matching Contributions" made pursuant to the 401(k) Plan) or to make any deferrals pursuant to any deferred compensation plan of the Company after the Termination Date. All payments due Employee under employee benefit plans or arrangements in which Employee participates, including without limitation, the 401 (k) Plan and any deferred compensation plan of the Company, shall be paid to Employee pursuant to the terms and provisions of such plans. Notwithstanding the foregoing, if, immediately prior to the Termination Date, Employee participates in certain Company employee welfare benefit plans, Employee's participation in such plans may continue on the same terms and conditions, including the same co-payment terms, until the last day of the month in which the Termination Date occurs.

4. **Release.**

a. *General Release*. In return for the consideration set forth in Sections 2(a) and (b) above, Employee, on behalf of himself or herself, as well as Employee’s heirs, beneficiaries, successors, representatives, trustees, administrators and assigns, freely and voluntarily hereby waives and releases the Company, and each of its past, present and future officers, directors, shareholders, employees, consultants, accountants, attorneys, agents, managers, insurers, sureties, parent and sister corporations, divisions, subsidiary corporations and entities, partners, joint venturers and affiliates (and each of their respective beneficiaries, successors, representatives and assigns) and all persons acting in concert with them (collectively, “Affiliates”) from any and all claims, demands, damages, debts, liabilities, controversies, obligations, actions or causes of action of any nature whatsoever, whether based on tort, statute, contract, indemnity, rescission or any other theory of recovery, and whether for compensatory, punitive, equitable or other relief, whether known, unknown, suspected or unsuspected, against the Company and/or its Affiliates, including without limitation claims which may have arisen or may in the future arise in connection with any event that occurred on or before the date of Employee’s execution of this Release.

These claims include but are not limited to claims arising under federal, state and local statutory or common law, including, but not limited to the Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq. (“ADEA”); Title VII of the Civil Rights Act of 1964, as amended by the Civil Rights Act of 1991, 42 U.S.C. § 2000 et seq.; Equal Pay Act, 29 U.S.C. § 206(d); the Civil Rights Act of 1866, 42 U.S.C. § 1981; the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; the False Claims Act, 31 U.S.C. § 3729 et seq.; the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq.; the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2101 et seq.; the California Fair Employment and Housing Act, Cal. Lab. Code § 12940 et seq.; the California Equal Pay Law, Cal. Lab. Code §§ 1197.5(a),1199.5; the Moore-Brown-Roberti Family Rights Act of 1991, Cal. Gov’t Code §§12945.2, 19702.3; the California WARN Act, Cal. Lab. Code § 1400 et seq.; the California Labor Code; the California Constitution; (all as amended) claims arising out of any legal restrictions on the Company’s right to terminate its employees; or claims arising under state and federal whistleblower statutes to the maximum extent permitted by law. Nothing herein shall be construed to impede the employee from communicating directly with, cooperating with or providing information to any government regulator.

b. *Unknown Claims*. Employee expressly waives any right or claim of right to assert hereafter that any claim, demand, obligation and/or cause of action has, through ignorance, oversight or error, been omitted from the terms of this Release. Employee makes this waiver with full knowledge of his or her rights and with specific intent to release both his or her known and unknown claims, and therefore specifically waives his or her rights under Section 1542 of the Civil

Code of California or other similar provisions of any other applicable law (collectively, "Section 1542"), which reads as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."

Employee understands and acknowledges the significance and consequence of this Release and of such specific waiver of Section 1542, and expressly agrees that this Agreement shall be given full force and effect according to each and all of its express terms and provisions, including those relating to unknown and unsuspected claims, demands, obligations and causes of action herein above specified.

c. *Claims Not Released*. This Release does not waive rights or claims under federal or state law that Employee cannot waive by private agreement, including, but not limited to those he or she may have under Sections 2800 and 2802 of the California Labor Code, the Employee's right to file a claim for unemployment benefits, worker's compensation benefits, claims under the Fair Labor Standards Act, health insurance benefits under COBRA, or claims with regards to vested benefits under a retirement plan governed by ERISA.

d. *Review and Revocation*. In accordance with the Older Workers Benefit Protection Act, Employee acknowledges and agrees this Agreement includes a waiver and release of all claims that Employee have or may have under the ADEA. With respect to the release of claims under the ADEA, Employee acknowledges that:

(i) This Agreement is written in a manner calculated to be understood by Employee and Employee understands it.

(ii) The waiver and release of claims under the ADEA contained in this Agreement does not cover rights or claims that may arise after the date on which Employee signs this Agreement.

(iii) This Agreement provides for consideration in addition to anything of value to which Employee is already entitled.

(iv) Employee is hereby advised to consult an attorney before signing this Agreement.

(v) Employee has been granted twenty-one (21) days after receiving this Agreement to decide whether or not to sign this Agreement. If Employee signs this Agreement prior to the expiration of the twenty-one (21) day period, Employee does so voluntarily and after having had the opportunity to consult with an attorney, and Employee hereby waives the remainder of the twenty-one (21) day period.

(vi) Employee has the right to revoke this Agreement within seven (7) days of signing this Agreement, and this Agreement shall not be enforceable or effective until the eighth (8th) day after he or she signs this Agreement (the “Effective Date”).

(vii) In the event this Agreement is revoked, this Agreement will be null and void in its entirety, and Employee will not be entitled to the payments and benefits provided in Section 2 of this Agreement. If Employee wishes to revoke this Agreement, Employee must deliver written notice stating his or her intent to revoke this Agreement to the Company’s _______________, on or before 5:00 p.m. on the seventh (7th) day after the date on which Employee signed this Agreement.

5. **No Future Actions.** To the extent permitted by law, Employee agrees that Employee shall not encourage, cooperate in, or initiate any suit or action of any kind, or voluntarily participate in same, individually or as a representative, witness or member of a class, under contract, law or regulation, federal, state or local, pertaining to any matter related to his or her employment with the Company. Employee represents that he or she has not, to date, initiated (or caused to be initiated) any such suit or action.

Employee agrees that if he or she, or anyone purporting to act on his or her behalf or under any assignment of claims from Employee, hereafter commences any suit arising out of, based upon, or relating to any of the claims released by the Agreement or in any manner asserts against the Company and/or its Affiliates, any of the claims released hereunder, then, to the maximum extent permitted by law, Employee will pay to the Company and/or its Affiliates, as applicable, in addition to any other damages caused to them thereby, all attorneys’ fees incurred by the Company and/or its Affiliates, as applicable, in defending or otherwise responding to said suit or claim.

The foregoing shall not apply if Employee is required to participate by legal process or other requirement of applicable law, provided that Employee gives the Company notice if legal process is served on the Employee; or to any challenge by Employee to the validity of any release herein of ADEA claims or to any to suit or action brought by Employee to assert such a challenge.

Additionally, nothing in this Release precludes Employee from participating in any investigation or proceeding before any federal or state agency, or governmental body, including, but not limited to, the Equal Employment Opportunity Commission, the Securities and Exchange Commission, and/or the Department of Justice. However, while Employee may file a charge, provide information, or participate in any investigation or proceeding, by signing this Release, Employee, to the maximum extent permitted by law, waives any right to bring a lawsuit against the Company, and waives any right to any individual monetary recovery in any such proceeding or lawsuit or in any proceeding brought based on any communication by Employee to any federal, state or local government agency or department.

6. **Cooperation with the Company.** In addition, Employee shall, without further compensation, cooperate with and assist the Company in the investigation of, preparation for or defense of any actual or threatened third party claim, investigation or proceeding involving the Company or its predecessors or affiliates and arising from or relating to, in whole or in part, Employee's employment with the Company or its predecessors or affiliates for which the Company requests Employee's assistance, which cooperation and assistance shall include, but not be limited to, providing truthful testimony and assisting in information and document gathering efforts. In connection herewith, it is agreed that the Company will use its reasonable best efforts to assure that any request for such cooperation will not unduly interfere with Employee's other material business and personal obligations and commitments.

7. **Return of Company Property.** Employee agrees he or she shall return to the Company immediately upon termination of employment any building key(s), security pass or other access or identification cards and any and all Company property in his or her possession, including but not limited to any books, documents, credit cards, computer equipment, software, mobile phones or data files. Employee agrees to submit all expense accounts and to pay promptly the outstanding balance on each corporate credit card that the Company previously issued to Employee. Compliance with this Section is a condition precedent to the Company's obligation to provide the payments and benefits set forth in Section 2.

8. **Confidential Information.** To the maximum extent permitted by law, Employee shall not, without the Company's written consent by an authorized representative, at any time prior or subsequent to the execution of this Release, disclose, use, remove or copy any Confidential Information, trade secret or proprietary information he or she acquired during the course of his or her employment by the Company. "Confidential Information," for purposes of this Agreement, includes any information not previously published or generally in the public domain. Confidential Information, trade secrets and proprietary information includes without limitation, any technical, actuarial, economic, financial, procurement, provider, enrollee, customer, underwriting, contractual, managerial, marketing or other information of any type regarding the business in which

the Company is engaged, but not including any previously published information or other information generally in the public domain. Employee also agrees that he or she shall not without the Company's written consent by an authorized representative, directly or indirectly use the Company's trade secret information, including but not limited to customer lists, to solicit business of any customers of the Company (other than on behalf of the Company). Employee acknowledges and agrees that any "Invention," including without limitation, any developments or discoveries by Employee during the course of his or her employment with the Company through the date of execution of this Release resulting in patents, lists of customers, trade secrets, specialized know-how or other intellectual property useful in the then-current business of the Company and any original works of authority are the property of the Company and shall be used for the sole benefit of the Company. If not previously assigned to the Company, Employee hereby assigns ownership of any and all Inventions to the Company, provided, however, that the provisions of this Agreement requiring assignment of Inventions to the Company do not apply to any invention which qualifies fully under the provisions of California Labor Code section 2870, which provides as follows:

"(a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either:

(1) Relate at the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or

(2) Result from any work performed by the employee for the employer.

(b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable."

This provision shall supplement, but not limit or supersede any other agreement between Employee and the Company concerning any Confidential Information or other intellectual property.

9. **Non-Solicitation.** In addition to any other part or term of this Release, Employee agrees that he or she shall not, for a period of one (1) year from the date of this Agreement, regardless of the reason for Employee's termination of employment, without the Company's written consent by an authorized representative, on his or her own behalf or on behalf of any other person, either directly or indirectly, solicit, recruit, encourage or induce any employee, agent, provider, vendor or independent contractor with whom Employee became acquainted during the course of employment to terminate such a person's or entity's relationship with the Company or to associate with a competitor of the Company. The prohibitions of this paragraph are not intended to deny employment

opportunities within the Employee’s field of employment but are limited only to those prohibitions necessary to protect the Company from unfair competition.

10. **No Disparagement.** Employee further agrees and acknowledges that in exchange for the consideration identified in Sections 2 (a) and (b) above, he or she shall not make any disparaging comments and/or statements to anyone either orally or in writing about the Company and/or its employees.

11. **No Admission.** Nothing contained herein shall be construed as an admission of any wrongful act, including, but not limited to, violation of any contract, express or implied, or any federal, state or local employment laws or regulations, and nothing contained herein shall be used for any purpose except in proceedings related to the enforcement of this Release.

12. **Arbitration of Disputes.** If there is any dispute between the Company and the Employee over the terms or obligations under this Release, that dispute shall be resolved by binding arbitration before a single neutral arbitrator who shall be a retired judge. The arbitration shall proceed in accordance with the then-current Employment Rules of the American Arbitration Association. The judgment of the arbitrator shall be final, binding and nonappealable, and may be entered in any state or federal court having jurisdiction thereafter. The arbitrator shall be bound to apply and follow the applicable state or federal laws in reaching a decision in this matter. Any disagreement regarding whether a dispute is required to be arbitrated pursuant to this Release shall be decided by the arbitrator. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall govern the interpretation and enforcement of this paragraph.

Notwithstanding the above paragraph, the arbitration procedure shall not prohibit Employee or the Company from seeking injunctive relief, including without limitation, temporary or preliminary injunctive relief, through any court of competent jurisdiction if such relief is not available or is not available in a timely manner, through arbitration.

13. **Confidentiality.** Employee represents and agrees that he or she will keep the terms, amounts and facts of this Release completely confidential, and that he or she will not hereafter disclose any information concerning this Release to anyone except his or her immediate family, attorneys or accountants or taxing authorities, except as may be required by law. Employee agrees that if Employee discloses this Release to anyone in his or her immediate family, his or her attorney(s), or his or her accountant(s), Employee will ensure that the individual to whom Employee discloses the Agreement understands that he or she is also subject to this confidentiality provision. Employee agrees that he or she is liable for any breach of this provision by his or her immediate family, attorney(s) or accountant(s), in the same manner and with the same consequences as if the Employee himself/herself had breached this provision. This provision shall not apply to any information that becomes generally known as a result of disclosure by the Company.

14. **Severability.** Should any part, term or provision of this Release be declared and/or be determined by any court or arbitrator to be illegal or invalid, the validity of the remaining

parts, terms or provisions shall not be affected thereby, and said illegal or invalid part, term or provision shall be deemed not to be a part of this Release.

15. **Entire Agreement/No Oral Modification.** This Release contains the entire agreement between the parties hereto, and fully supersedes any and all prior agreements or understandings between the parties hereto pertaining to the subject matter hereof. There may be no modification of the terms of this Release except in writing signed by the parties hereto.

16. **Opportunity to Consult with Counsel.** Employee acknowledges that he or she has had an opportunity to consult with and be represented by counsel of Employee's choosing in the review of this Release, that he or she has been advised by the Company to do so, that the Employee is fully aware of the contents of the Release and of its legal effect, that the preceding paragraphs recite the sole consideration for this Release, and that Employee enters into this Release freely, without duress or coercion, and based on the Employee's own judgment and wishes and not in reliance upon any representation or promise made by the Company, other than those contained herein.

17. **Choice of Law.** Except as otherwise stated herein, this Release shall in all respects be interpreted, enforced and governed under the laws of the State of California. The language of all parts of this Release shall in all cases be construed as a whole, according to its fair meaning, and not strictly for or against any of the parties.

18. **Reformation.** In the event any part, term or provision herein is not enforceable including because its geographic scope, length or subject matter is determined to be excessive, then such part, term or provision shall be reformed to the minimum extent necessary to make such part, term or provision enforceable.

19. **Outplacement and Section 409A.** To the extent that the outplacement services provided under Section 2(a) and/or the continued health benefits payable under Section 2(b) constitute non-exempt "nonqualified deferred compensation" (within the meaning of Section 409A) that is subject to Section 409A, such benefits shall be provided in a manner that complies with the requirements of Treasury Regulation Section 1.409A-3(i)(1)(iv), including, without limitation, the following conditions: (i) the benefits payable in Employee's taxable year may not affect such benefits that Employee is eligible to receive in another taxable year of Employee; (ii) the reimbursement of expenses or provision of in-kind benefits shall be made on or before the last day of Employee's taxable year following the taxable year in which the expense or obligation is incurred; and (iii) such benefits shall not be subject to liquidation or exchange for another benefit.

20. **Headings.** The headings of the Sections of this Agreement are provided for convenience only. They do not alter or limit, in any way, the text of any Section of this Agreement.

21. **Acceptance and Expiration.** Employee has up to twenty-one (21) calendar days from the date he or she receives this document to consider and accept the terms of this Release, but may accept it at any time within those twenty-one (21) calendar days. Employee

agrees that changes to the terms or form of this Release, whether material or immaterial do not restart the running of the twenty-one (21) day period. After twenty-one (21) calendar days have passed, this offer will expire.

Exhibit 10.6

EMPLOYEE ACKNOWLEDGES BY SIGNING BELOW that (i) Employee has not relied upon any representations, written or oral, not set forth in this Release; (ii) at the time Employee was given this Release, Employee was informed in writing by the Company that: (a) Employee had at least twenty-one (21) calendar days in which to consider whether Employee would sign the Release; (b) Employee was advised to consult with an attorney before signing the Release; and (c) Employee had seven (7) calendar days to revoke this Agreement after signing it; (iii) Employee had an opportunity to consult with an attorney and either had such consultations or has freely decided to sign this Release without consulting an attorney; and (iv) Employee executes this Release knowingly and voluntarily.

IN WITNESS WHEREOF, the parties hereto have executed this Release as of the dates set forth below.

Employee Health Net, Inc.

By: By: ______________________________
Name: Name:
Title:

Dated: Dated: ____________________________

NOTE: Please return your signed waiver and release to:
Organization Effectiveness Unit
Attention: (Name, Title)
(Address, City, State, Zip Code)

Exhibit 10.7

AMENDED AND RESTATED
EMPLOYMENT AGREEMENT

This AMENDED AND RESTATED EMPLOYMENT AGREEMENT (this “Agreement”) is made and entered into as of February 25, 2015, by and between Health Net, Inc., a Delaware corporation (the “Company”), with its principal place of business located at 21650 Oxnard Street, Woodland Hills, California 91367, and Scott D. Law (“Executive”). This Agreement amends and restates the Prior Agreement (as defined below) in its entirety.

RECITALS

WHEREAS, the Company and Executive previously entered into that certain Amended and Restated Employment Agreement dated March 11, 2013 (the “Prior Agreement”); and

WHEREAS, the Company and Executive desire to amend and restate the Prior Agreement on the terms and conditions set forth herein, and to supersede the Prior Agreement in all respects effective as of October 9, 2014 (the “Effective Date”).

NOW, THEREFORE, in consideration of the following covenants, conditions and promises contained herein, and other good and valuable consideration, the Company and Executive hereby agree as follows:

1. Duties and Salary.

A. Duties. Executive’s title is Health Care Services Officer, but may be changed at the discretion of the Company to a title that reflects a similarly situated senior executive position. Executive shall report directly to James E. Woys, Executive Vice President, Chief Financial and Operating Officer and Interim Treasurer of the Company, but Executive’s reporting relationship may be changed from time to time at the discretion of the Company. Executive’s duties and responsibilities include being accountable for the design, managed care effectiveness and cost efficiency of Medical Management, Provider Management and Contracting across all lines of business (except Federal Services) and five regional geographies. Executive’s duties and responsibilities also include integrating strategic planning and tactical execution of healthcare delivery strategies that ensure the best possible quality of care for the Company’s members, while supporting the Company’s goals and objectives. However, the Company reserves the right to assign Executive other duties as needed and to change Executive’s duties from time to time on reasonable notice, based on Executive’s skills and the needs of the Company. In the event that Executive performs any such additional duties, Executive shall not be entitled to an increase in compensation beyond that specified in this Agreement.

B. Salary. As of February 21, 2015, Executive will be paid a base salary at the annual rate of $537,686, which salary will be paid on a pro-rated bi-weekly basis, less applicable withholdings ("Base Salary"), covering all hours worked. Generally, Executive's Base Salary will be reviewed annually, but the Company reserves the right to change Executive's compensation from time-to-time. Pursuant to the charter of the Compensation Committee of the Company's Board of Directors (the "Committee"), any adjustment to Executive's compensation must be made with the approval of the Committee and, in the event that Executive constitutes one of the top two (2) highest paid executive officers of the Company, with the ratification of the Company's Board of Directors.

A. Disclosure of Personal Compensation Information. As an "executive officer" of the Company (as such term is defined in the rules and regulations of the Securities and Exchange Commission ("SEC")), information regarding Executive's employment arrangements with the Company, including, among other things, the terms of this Agreement and any stock option agreement, restricted stock agreement, restricted stock unit agreement, performance share agreement and/or severance agreement Executive enters into with the Company from time to time (collectively, "Personal Compensation Information"), may be disclosed in filings with the SEC, the New York Stock Exchange ("NYSE") and/or other regulatory organizations upon the occurrence of certain triggering events. Such triggering events include, but are not limited to, the execution of this Agreement and any amendments thereto, changes in Executive's Base Salary, any annual incentive payment (whether in the form of cash or equity) awarded to Executive (in the past or after the date hereof), and the establishment of performance goals under the Company's incentive plans. Executive's execution of this Agreement will serve as Executive's acknowledgement that Executive's Personal Compensation Information may be publicly disclosed from time to time in filings with the SEC, NYSE or otherwise as necessary.

2. Adjustments and Changes in Employment Status. Executive understands that the Company reserves the right to make personnel decisions regarding Executive's employment, including, but not limited to, decisions regarding any promotion, salary adjustment, transfer or disciplinary action, up to and including Termination (as defined below), consistent with the needs of the business of the Company.

For purposes of this Agreement, the capitalized terms "Termination" and "Terminate," shall mean Executive's Separation from Service (as defined below) from the Company. A "Separation from Service" with respect to Executive shall mean a "separation from service," as defined in Treasury Regulation Section 1.409A-1(h) or any regulation that supersedes such regulation.

3. Protection of Proprietary and Confidential Information. Executive agrees that Executive's employment creates a relationship of confidence and trust with the Company with respect to Proprietary and Confidential Information (as defined below) of the Company learned by Executive during Executive's employment.

A. Executive agrees not to directly or indirectly use or disclose any of the Proprietary and Confidential Information of the Company or any of its affiliates at any time except in connection with the services Executive provides to such entities. "Proprietary and Confidential Information" shall mean trade secrets, confidential knowledge, data or any other proprietary or confidential information of the Company or any of its affiliates, or of any customers, members, employees or directors of any of such entities, but shall not include any information that (i) was publicly known and made generally available in the public domain prior to the time of disclosure to Executive by the Company or (ii) becomes publicly known and made generally available after disclosure to Executive by the Company other than as a result of a disclosure by Executive in violation of this Agreement. By way of illustration but not limitation, "Proprietary and Confidential Information" includes: (i) trade secrets, documents, memoranda, reports, files, correspondence, lists and other written and graphic records affecting or relating to any such entity's business; (ii) confidential marketing information including without limitation marketing strategies, customer and client names and requirements, services, prices, margins and costs; (iii) confidential financial information; (iv) personnel information (including without limitation employee compensation); and (v) other confidential business information.

B. Executive further agrees that at all times during Executive's employment and thereafter, Executive will keep in confidence and trust all Proprietary and Confidential Information, and that Executive will not use or disclose any Proprietary and Confidential Information or anything related to such information without the written consent of the Company, except as may be necessary in the ordinary course of performing Executive's duties to the Company.

C. All Company property, including, but not limited to, Proprietary and Confidential Information, documents, data, records, apparatus, equipment and other physical property, whether or not pertaining to Proprietary and Confidential Information, provided to Executive by the Company or any of its affiliates or produced by Executive or others in connection with Executive's providing services to the Company or any of its affiliates shall be and remain the sole property of the Company or its affiliates (as the case may be) and shall be returned promptly to such appropriate entity as and when requested by such entity. Executive shall return and deliver all such property upon termination of Executive's employment, and Executive may not take any such property or any reproduction of such property upon such termination.

D. Executive recognizes that the Company and its affiliates have received and in the future will receive information from third parties which is private, proprietary or confidential information subject to a duty on such entity's part to maintain the confidentiality of such information and to use it only for certain limited purposes. Executive agrees that during Executive's employment, and thereafter, Executive owes such entities and such third parties a duty to hold all such private, proprietary or confidential information received from third parties in the strictest confidence and not to disclose it, except as necessary in carrying out Executive's work for such entities consistent with such entities' agreements with such third parties, and not to use it for the benefit of anyone other than for such entities or such third parties consistent with such entities' agreements with such third parties.

E. Executive's obligations under this Section 3 shall continue after the Termination of Executive's employment and any breach of this Section 3 shall be a material breach of this Agreement.

4. Physical Exam. Beginning in 2013, Executive shall be required, on an annual basis, to undergo a physical examination and to send evidence that Executive has undergone such exam (but in no case the results of such exam) to the Senior Vice President of Organization Effectiveness. The Company shall reimburse Executive for any out-of-pocket expenses relating to the physical examination that are not otherwise covered by Executive's health insurance plan.

5. Representations and Warranties of Executive.

A. No Violation; No Conflicts. Executive represents and warrants to the Company that the entering into of this Agreement and Executive's performance of Executive's duties hereunder, will not violate any agreements with, or trade secrets of, any other person or entity. Executive further represents and warrants that Executive does not have any relationship or commitment to any other person or entity that might be in conflict with Executive's obligations to the Company under this Agreement, including but not limited to outside employment, sales broker relationships, investments or business activities. Executive understands and agrees that while employed by the Company Executive is expected to refrain from engaging in any outside activities that might be in conflict with the business interests of the Company. In addition, Executive represents and warrants to the Company that Executive has not shared with or disclosed to, and will not share with or disclose to, the Company any proprietary or confidential information of Executive's previous employers or any other third party.

B. Legal Proceedings. Executive represents and warrants to the Company that Executive has not been arrested, indicted, convicted or otherwise involved in any criminal or civil action or legal matter that could affect Executive's ability to perform Executive's duties hereunder or that may have a negative impact on the Company, its reputation or its operations. Executive agrees, to the extent permitted by applicable law, to notify the Company's Senior Vice President of Organization Effectiveness immediately in the event that Executive becomes party to any criminal or civil action or other legal matter in the future that could have an affect on the foregoing representation.

6. Executive Benefits.

A. Employee Benefit Programs. Executive shall be eligible to participate in the Company's various employee benefit programs and plans in place from time to time in accordance with their terms, as long as Executive remains employed by the Company and Executive meets the applicable participation requirements. These benefit programs and plans currently include paid time off ("PTO"), holidays, group medical, dental, vision, term life, and short and long term disability insurance and participation in the Company's 401(k) plan, tuition reimbursement plan and deferred compensation plan. The Company or its subsidiaries or affiliates may modify, terminate or amend any benefit or plan in its discretion, retroactively or prospectively, subject only to applicable law.

B. Required Insurance. Executive will be covered by workers' compensation insurance and state disability insurance, as required by state law.

C. Fringe Benefits. Executive will be entitled to such fringe benefits and perquisites as are provided by the Company from time to time, in accordance with the Company's policies, practices and procedures, and shall receive such additional fringe benefits and perquisites as the

Company may, in its discretion, from time-to-time provide. Without limiting the generality of the foregoing, Executive will be entitled to be reimbursed up to the amount of $5,000 per year for documented costs incurred for personal financial counseling services provided to Executive, including tax preparation, as long as Executive remains employed by the Company.

A. Incentive Bonus. Executive will be eligible to participate in the Health Net, Inc. Management Incentive Plan, or such other Company bonus plan that may be in effect from time to time, in accordance with the terms of such plan, which provides Executive with a target bonus for each plan year equal to 80% of Executive's Base Salary as additional compensation according to the terms of such plan. The actual bonus payment will range from 0% to 200% of target depending upon the actual results achieved. It is understood that the Committee and the Company will award bonus amounts, if any, as it deems appropriate consistent with the MIP or such other bonus plan that may be in effect from time to time.

B. Expenses. Subject to and in accordance with the Company's written policies for business and travel expenses, Executive will receive reimbursement for all business travel and other out-of-pocket expenses reasonably incurred by Executive in the performance of Executive's duties pursuant to this Agreement.

7. Equity Grants; Stock Ownership Requirement.

A. Future Equity Grants. Any future equity grants made to Executive will be granted under one of the Company's Long-Term Incentive Plans, and will be subject to the terms of such plan and of the agreement executed in connection with such grant. Any future equity grants to Executive will be made at the discretion of the Committee.

B. Company Stock Ownership Requirement. In accordance with the Executive Officer Stock Ownership Policy adopted by the Board of Directors of the Company, as may be amended from time to time (the "Executive Stock Ownership Policy"), Executive is currently required to own "Qualifying Shareholdings" (as defined in the Executive Stock Ownership Policy) having a value of one time (1x) Executive's Base Salary in effect from time to time pursuant to this Agreement (the "Stock Ownership Requirement"). The number of Qualifying Shareholdings Executive is required to own will be calculated based on the average NYSE closing price per share of the Company's Common Stock (as adjusted for stock splits and similar changes to the Common Stock) for the most recently completed fiscal year of the Company.

Using Executive's Base Salary as of February 21, 2015, which was $537,686, and a stock price of $41.04, which was the average closing price per share of the Company's Common Stock for the fiscal year ended December 31, 2014, Executive's Stock Ownership Requirement as of February 21, 2015 was 13,102 shares ("Target Amount"). The Target Amount is subject to change from time to time based on (1) changes in the average closing price per share of the Company's Common Stock on an annual basis, (2) any changes in Executive's Base Salary made pursuant to and in accordance with Section 1(B) of this Agreement, and (3) any changes under the terms of the Executive Stock Ownership Policy.

Under the Executive Stock Ownership Policy as currently in effect, to the extent that Executive has not achieved the Stock Ownership Requirement, Executive must hold 75% of all "net settled shares" received from the vesting, delivery or exercise of equity awards granted under the Company's equity award (including long-term incentive) plans, as such term is defined in the Executive Stock Ownership Policy.

The Committee expects that Executive will make reasonable progress toward Executive's Stock Ownership Requirement. Executive will be notified on an annual basis of any changes in Executive's Target Amount.

8. Term of Employment. Executive's employment with the Company is at the mutual consent of Executive and the Company. Nothing in this Agreement is intended to guarantee Executive's continuing employment with the Company or employment for any specific length of time. Accordingly, either Executive or the Company may terminate the employment relationship at any time and for any reason whatsoever (or for no reason), subject to certain notice requirements, to the extent applicable, as set forth herein. Upon Termination of Executive's employment for any reason, in addition to any other payments that may be payable to Executive hereunder, Executive (or Executive's beneficiaries or estate) shall be paid (in each case to the extent not theretofore paid) within thirty (30) days following Executive's date of Termination (or such shorter period that may be required by applicable law): (a) Executive's annual Base Salary through such Termination date, (b) accrued but unused PTO, (c) reimbursable expenses incurred by Executive prior to the Termination date and (d) amounts to which Executive may be entitled through such Termination date under any other compensatory plan, arrangement or program payment in accordance with the terms thereunder. This Agreement constitutes a final and fully binding integrated agreement with respect to the at-will nature of the employment relationship.

9. Termination of Employment/Severance Pay.

A. Termination Without Cause Not Following Change in Control. If Executive's employment is Terminated by the Company without "Cause" (as defined in Section 9(D) below) at any time that is not within two (2) years after a "Change in Control" (as defined below) of Health Net, Inc., Executive will be entitled to receive, within thirty (30) days following the Termination of Executive's employment, provided that Executive signs and delivers prior to the expiration of such (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) a lump sum cash payment equal to twelve (12) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, and (ii) the continuation, under COBRA, of Executive's medical, dental and vision benefits (as maintained for Executive's benefit immediately prior to the date of Executive's Termination) (the "Benefits") for Executive and Executive's dependents for a period of twelve (12) months following the effective date of Executive's Termination, with premium payments paid by the Company on Executive's behalf as they become due, provided, that Executive properly elects to continue those benefits under COBRA.

For purposes of this Agreement, "Change in Control" is defined as any of the following which occurs subsequent to the Effective Date:

(i) Any person (as such term is defined under Section 13(d)(3) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”)), corporation or other entity (other than Health Net, Inc. or any of its subsidiaries, or any employee benefit plan sponsored by Health Net, Inc. or any of its subsidiaries) is or becomes the beneficial owner (as such term is defined in Rule 13d-3 under the Exchange Act) of securities of Health Net, Inc. representing twenty percent (20%) or more of the combined voting power of the outstanding securities of Health Net, Inc. which ordinarily (and apart from rights accruing under special circumstances) have the right to vote in the election of directors (calculated as provided in paragraph (d) of such Rule 13d-3 in the case of rights to acquire Health Net, Inc.’s securities) (the “Securities”);

(ii) As a result of a tender offer, merger, sale of assets or other major transaction, the persons who are directors of Health Net, Inc. immediately prior to such transaction cease to constitute a majority of the Board of Directors of Health Net, Inc. (or any successor corporations) immediately after such transaction;

(iii) Health Net, Inc. is merged or consolidated with any other person, firm, corporation or other entity and, as a result, the shareholders of Health Net, Inc., as determined immediately before such transaction, own less than eighty percent (80%) of the outstanding Securities of the surviving or resulting entity immediately after such transaction:

(iv) A tender offer or exchange offer is made and consummated for the ownership of twenty percent (20%) or more of the outstanding Securities of Health Net, Inc.;

(v) Health Net, Inc. transfers substantially all of its assets to another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc.; or

(vi) Health Net, Inc. enters into a management agreement with another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc. and such management agreement extends hiring and firing authority over Executive to an individual or organization other than Health Net, Inc.

B. Termination Without Cause or For Good Reason Following Change in Control. If at any time within two (2) years after a Change in Control of Health Net, Inc. Executive’s employment is Terminated by the Company without Cause or Executive Terminates Executive’s employment for “Good Reason” (as defined below) (by giving the Company at least fourteen (14) days prior written notice of the effective date of Termination), then Executive will be entitled to receive, within thirty (30) days following the Termination of Executive’s employment, provided that Executive signs and delivers prior to the expiration of such thirty (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) a lump sum payment equal to twenty-four (24) months of Executive’s Base Salary in effect immediately prior to the date of Executive’s Termination, and (ii) the continuation of Executive’s Benefits for six (6) months following Executive’s date of Termination, and (iii) and after expiration of such six (6) months Benefits continuation period, the continuation, under COBRA, of Benefits for Executive and Executive’s dependents for an additional period of eighteen (18) months following the effective date of Executive’s Termination with premium payments made by the Company on Executive's behalf, provided, that Executive properly elects to continue those benefits under COBRA, and provided, further, that in the event the Company requests, in writing, prior to such voluntary Termination by Executive for Good Reason that Executive continue in the employ of the Company for a period of time up to 90 days following such Change in Control, then Executive shall forfeit such severance allowance if Executive voluntarily leaves the employ of the Company prior to the expiration of such period of time.

For purposes of this Agreement, the term "Good Reason" means any of the following which occurs, without Executive's consent, subsequent to the effective date of a Change in Control as defined above:

(i) A substantial reduction in the scope of Executive's authority, duties or responsibilities with the Company, except in connection with the Termination of Executive's employment for Disability (as defined below), normal retirement or Cause or by Executive voluntarily other than for Good Reason;

(ii) A material reduction by the Company in Executive's base compensation (*i.e.*, Executive's Base Salary and/or target annual bonus) as in effect immediately prior to any such reduction;

(iii) A relocation of Executive to a work location more than fifty (50) miles from Executive's work location immediately prior to such proposed relocation; provided that such proposed relocation results in a materially greater commute for Executive based on Executive's residence immediately prior to such relocation; or

(iv) The failure of the Company to obtain an assumption agreement from any successor contemplated under Section 12 of this Agreement;

provided, however, that (a) Executive provides written notice to the Company of the existence of the condition described above within ninety (90) days of the initial existence of the condition, (b) the Company fails to cure such condition within thirty (30) days after receipt of such written notice, and (c) the date of Executive's Termination occurs no later than seventy-five (75) days after the initial occurrence of the event constituting Good Reason, in accordance with Treasury Regulation Section 1.409A-1(n)(2)(ii).

C. Voluntary Termination. Notwithstanding anything to the contrary in this Agreement, whether express or implied, Executive may at any time Terminate Executive's employment for any reason by giving the Company fourteen (14) days prior written notice of the effective date of Termination. In the event that Executive voluntarily Terminates employment with the Company (except for Good Reason within two (2) years after a Change in Control of Health Net, Inc., as described in Section 9 (B) hereof), then Executive shall not be eligible to receive any payments or continuation of Benefits set forth in this Section 9.

A. Termination by the Company for Cause. The Company may Terminate Executive's employment for "Cause" at any time with or without advance notice. In the event of such Termination, Executive will not be eligible to receive any of the payments set forth in Section 9(A) or 9(B) above. For purposes of this Agreement, a Termination for "Cause" is defined as: (i) an act of dishonesty causing harm to the Company or any of its affiliates, (ii) the material breach of either the Company's Code of Business Conduct and Ethics (the "Code of Conduct") or any policy or procedure developed and published by the Company regarding compliance or ethics related to the Code of Conduct, (iii) habitual drunkenness or narcotic drug addiction, (iv) conviction of, or entry by Executive of a guilty or no contest plea to, the commission of a felony or a misdemeanor involving moral turpitude, (v) willful refusal to perform or gross neglect of the duties assigned to Executive, (vi) the willful breach of any law that, directly or indirectly, affects the Company or any of its affiliates, (vii) a material breach by Executive following a Change in Control of those duties and responsibilities of Executive that do not differ in any material respect from Executive's duties and responsibilities during the 90-day period immediately prior to such Change in Control (other than as a result of incapacity due to physical or mental illness) which is demonstrably willful and deliberate on Executive's part, which is committed in bad faith or without reasonable belief that such breach is in the best interests of the Company or any of its affiliates and which is not remedied in a reasonable period of time after receipt of written notice from the Company specifying such breach, or (viii) breach of Executive's obligations hereunder (or under any Company policy) to protect the proprietary and confidential information of the Company or any of its affiliates.

B. Termination Due to Death or Disability. In the event that Executive's employment is Terminated at any time due to Executive's death or "Disability" (as defined below), Executive (or Executive's beneficiaries or estate) shall be entitled to receive, provided Executive (or Executive's beneficiaries or estate, as applicable) signs a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) continuation of Executive's Benefits for a period of twelve (12) months from the date of Termination and (ii) a lump sum payment equal to twelve (12) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, to be paid within thirty (30) days following Executive's Termination of employment. For purposes of this Agreement, a Termination for "Disability" shall mean a Termination of Executive's employment due to Executive's absence from Executive's duties with the Company on a full-time basis for at least 180 consecutive days as a result of Executive's incapacity due to physical or mental illness which is determined to be total and permanent by a physician selected by the Company or its insurers.

10. Withholding. All payments required to be made by the Company hereunder to Executive or Executive's estate or beneficiaries shall be subject to the withholding of such amounts relating to taxes as the Company may reasonably determine should be withheld pursuant to any applicable law or regulation.

11. Restrictive Covenants.

A. Non-Competition. Executive hereby agrees that, during (i) the six (6)-month period following a Termination of Executive's employment with the Company that entitles Executive to receive severance benefits under this Agreement or a written agreement with or policy of the Company or (ii) the twelve (12)-month period following a Termination of Executive's employment with the Company that does not entitle Executive to receive such severance benefits (the period referred to in either clause (i) or (ii), the "Restricted Period"), Executive shall not undertake any employment or activity (including, but not limited to, consulting services) with a

Competitor (as defined below) in any geographic area in which the Company or any of its affiliates operate (the "Market Area"), where the loyal and complete fulfillment of the duties of the competitive employment or activity would call upon Executive to reveal, to make judgments on or otherwise use or disclose any confidential business information or trade secrets of the business of the Company or any of its affiliates to which Executive had access during Executive's employment with the Company. For purposes of this Section, "Competitor" shall refer to any health maintenance organization or insurance company that provides managed health care or related services similar to those provided by the Company or any of its affiliates.

B. Non-Solicitation. In addition, Executive agrees that, during the applicable Restricted Period following Termination of Executive's employment with the Company, Executive shall not, directly or indirectly, (i) solicit, interfere with, hire, offer to hire or induce any person, who is or was an employee of the Company or any of its affiliates at the time of such solicitation, interference, hiring, offering to hire or inducement, to discontinue his/her relationship with the Company or any of its affiliates or to accept employment by, or enter into a business relationship with, Executive or any other entity or person or (ii) solicit, interfere with or otherwise contact any customer or client of the Company or any of its affiliates.

C. Modification of Restrictions. It is hereby further agreed that if any court of competent jurisdiction shall determine that the restrictions imposed in this Section 11 are unreasonable (including, but not limited to, the definition of Market Area or Competitor or the time period during which this provision is applicable), the parties hereto hereby agree to any restrictions that such court would find to be reasonable under the circumstances.

D. Injunction Rights. Executive also acknowledges that the services to be rendered by Executive to the Company are of a special and unique character, which gives this Agreement a peculiar value to the Company or any of its affiliates, the loss of which may not be reasonably or adequately compensated for by damages in an action at law, and that a material breach or threatened breach by Executive of any of the provisions contained in this Section 11 will cause the Company or any of its affiliates irreparable injury. Executive therefore agrees that the Company may be entitled, in addition to the remedies set forth above in this Section 11 and any other right or remedy, to a temporary, preliminary and permanent injunction, without the necessity of proving the inadequacy of monetary damages or the posting of any bond or security, enjoining or restraining Executive from any such violation or threatened violations.

12. Successors; Binding Agreement.

A. Survival Following Merger, Consolidation or Asset Transfer. This Agreement shall not be terminated by any merger or consolidation of the Company whereby the Company is or is not the surviving or resulting corporation or as a result of any transfer of all or substantially all of the assets of the Company. In the event of any such merger, consolidation or transfer of assets, the provisions of this Agreement shall be binding upon the surviving or resulting corporation or the person or entity to which such assets are transferred.

B. Survivor's Assumption of Agreement. The Company agrees that concurrently with any merger, consolidation or transfer of assets referred to in this Section 12, it will cause any successor or transferee to unconditionally assume, by written instrument delivered to Executive (or

Executive's beneficiary or estate), all of the obligations of the Company hereunder. Failure of the Company to obtain such assumption prior to the effectiveness of any such merger, consolidation or transfer of assets shall entitle Executive to compensation and other benefits from the Company in the same amount and on the same terms as Executive would be entitled hereunder if Executive's employment were Terminated without Cause. For purposes of implementing the foregoing, the date on which any such merger, consolidation or transfer becomes effective shall be deemed the date of Termination.

C. Enforceability. This Agreement shall inure to the benefit of and be enforceable by Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees. If Executive shall die while any amounts would be payable to Executive hereunder had Executive continued to live, all such amounts, unless otherwise provided herein, shall be paid in accordance with the terms of this Agreement to such person or persons appointed in writing by Executive to receive such amounts or, if no person is so appointed, to Executive's estate.

13. Limitation on Payments.

A. Notwithstanding any other provisions of this Agreement, in the event that any payment or benefit received or to be received by Executive (including any payment or benefit received in connection with a Change in Control or the termination of Executive's employment, whether pursuant to the terms of this Agreement or any other plan, arrangement or agreement) (all such payments and benefits, including the payments and benefits under Section 9 hereof, being hereinafter referred to as the "Total Payments") would be subject (in whole or part), to the excise tax imposed under Section 4999 of the Internal Revenue Code of 1986, as amended (the "Code") (the "Excise Tax"), then, after taking into account any reduction in the Total Payments provided by reason of Section 280G of the Code in such other plan, arrangement or agreement, the cash severance payments shall first be reduced, and the non-cash severance payments shall thereafter be reduced, to the extent necessary so that no portion of the Total Payments is subject to the Excise Tax, but only if (i) the net amount of such Total Payments, as so reduced (and after subtracting the net amount of federal, state and local income taxes on such reduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such reduced Total Payments), is greater than or equal to (ii) the net amount of such Total Payments without such reduction (but after subtracting the net amount of federal, state and local income taxes on such Total Payments and the amount of Excise Tax to which Executive would be subject in respect of such unreduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such unreduced Total Payments). The Total Payments shall be reduced by the Company in its reasonable discretion in the following order: (A) reduction of any cash severance payments otherwise payable to Executive that are exempt from Section 409A (as defined below), (B) reduction of any other cash payments or benefits otherwise payable to Executive that are exempt from Section 409A, but excluding any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A, (C) reduction of any other payments or benefits otherwise payable to Executive on a pro-rata basis or such other manner that complies with Section 409A, but excluding any payments attributable to the acceleration of vesting and payments with respect to any stock option or other equity award with respect to the Company's

Common Stock that are exempt from Section 409A, and (D) reduction of any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A.

B. For purposes of determining whether and the extent to which the Total Payments will be subject to the Excise Tax, (i) no portion of the Total Payments the receipt or enjoyment of which Executive shall have waived at such time and in such manner as not to constitute a "payment" within the meaning of Section 280G(b) of the Code shall be taken into account, (ii) no portion of the Total Payments shall be taken into account which, in the written opinion of independent auditors of nationally recognized standing ("Independent Advisors") selected by the Company, does not constitute a "parachute payment" within the meaning of Section 280G(b)(2) of the Code (including by reason of Section 280G(b)(4)(A) of the Code) and, in calculating the Excise Tax, no portion of such Total Payments shall be taken into account which, in the opinion of Independent Advisors, constitutes reasonable compensation for services actually rendered, within the meaning of Section 280G(b)(4)(B) of the Code, in excess of the "base amount" (as defined in Section 280G(b)(3) of the Code) allocable to such reasonable compensation, and (iii) the value of any non-cash benefit or any deferred payment or benefit included in the Total Payments shall be determined by the Independent Advisors in accordance with the principles of Sections 280G(d)(3) and (4) of the Code.

14. Section 409A of the Internal Revenue Code. It is the intention of the Company and Executive that this Agreement not result in unfavorable tax consequences to Executive under Section 409A of the Code, and the Treasury Regulations and Internal Revenue Service guidance promulgated thereunder ("Section 409A") and the Agreement shall be interpreted, construed and administered as to so comply with, or be exempt from, Section 409A. Notwithstanding anything to the contrary herein, the Company and Executive agree to the provisions set forth in this Section 14 in order to comply with, or be exempt from, the requirements of Section 409A.

A. If Executive is a "specified employee" (as determined under the Company's Specified Employee Policy as in effect from time to time, or, in the absence of such policy, within the meaning of Section 409A) with respect to the Company, any non-exempt non-qualified deferred compensation that is subject to Section 409A and otherwise payable to or in respect of Executive in connection with Executive's Separation from Service pursuant to this Agreement shall be delayed until the earlier of (i) the expiration of six (6) months measured from the date of Executive's Separation from Service, or (ii) the date of Executive's death. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

B. All incentive bonus payments described in Section 6(D) shall be paid to Executive, to the extent earned, in no event later than the last day of the "applicable 2-1/2 month period", as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

C. With respect to the Company's reimbursement obligations under Sections 6(C) and 6(E) hereof and the provision of Benefits to Executive, (i) in no event shall any such reimbursements or in-kind benefits be made or provided later than the last day of Executive's taxable year following the taxable year in which the fee or expense was incurred, (ii) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during Executive's taxable year may not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year of Executive, and (iii) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit, in accordance with Treasury Regulation Section 1.409A-3(i)(1)(iv).

D. The Company and Executive agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by Executive due to any failure to comply with Section 409A. To the extent payments and benefits under this Agreement are subject to Section 409A, and such payments and benefits do not so comply, the Company shall amend this Agreement, or take such other actions as the Company deems reasonably necessary or appropriate, to comply with Section 409A. If any provision of the Agreement would cause such payments and benefits to fail to so comply, such provision shall not be effective and shall be null and void with respect to such payments or benefits, and such provision shall otherwise remain in full force and effect.

15. Company Policies. Executive's employment with the Company is subject to the terms and conditions contained in the Company's Associate Policies, including those located on HR Link, which can be accessed through the Company's intranet site, as in effect from time to time (the "Associate Policies"), the content of which is incorporated by reference herein. Executive shall be required to read, understand and comply with the Associate Policies.

16. Compensation Recovery (Clawback). Notwithstanding anything in this Agreement to the contrary, any compensation payable to Executive under this Agreement that constitutes "Incentive Compensation" (as such term is defined under the Company's Compensation Recovery Policy, as such policy may be amended from time to time (the "Compensation Recovery Policy")) shall be subject to the terms and conditions of the Compensation Recovery Policy.

17. Severability. If any term of this Agreement is held to be invalid, void or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected and the parties shall use their best efforts to find an alternative way to achieve the same result.

18. Integrated Agreement. This Agreement supersedes any prior agreements, representations or promises of any kind, whether written, oral, express or implied between the parties hereto with respect to the subject matters herein, including the Prior Agreement. It constitutes the full, complete and exclusive agreement between Executive and the Company with respect to the subject matters herein. This Agreement cannot be changed unless in writing, signed by Executive and a duly authorized officer of the Company and approved by the Board of Directors of the Company (or the Committee or its delegate, if permitted by the Committee's charter). The Company acknowledges and agrees that nothing contained herein shall be deemed to supercede, amend or otherwise modify the terms of the Indemnification Agreement dated March 7, 2013 between Executive and the Company.

19. Waiver. No waiver of any default hereunder shall operate as a waiver of any subsequent default. Failure by either party to enforce any of the terms or conditions of this Agreement, for any length of time or from time to time, shall not be deemed to waive or decrease the rights of such party to insist thereafter upon strict performance by the other party.

20. Notices. All notices and communications required or permitted hereunder shall be in writing and shall be deemed given (a) if delivered personally, (b) upon confirmation of receipt by the sender after being sent by electronic mail, (c) one (1) business day after being sent by Federal Express or a similar commercial overnight service, or (d) three (3) business days after being mailed by registered or certified mail, return receipt requested, prepaid and addressed to the following addresses, or at such other addresses as the parties may designate by written notice in the manner aforesaid:

If to the Company: Health Net, Inc.
21650 Oxnard Street, 22nd Floor
Woodland Hills, CA 91367
Attention: General Counsel

If to Executive: Scott D. Law
21650 Oxnard Street, 23rd Floor
Woodland Hills, CA 91367

21. Governing Law. The interpretation, construction and performance of this Agreement shall be governed by and construed and enforced in accordance with the internal laws of the State of Delaware without regard to the principle of conflicts of laws. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provisions of this Agreement, which other provisions shall remain in full force and effect.

22. Survival and Enforcement. Sections 3, 8, 9, 11, 12, 13, 14 and 16 of this Agreement and any rights and remedies arising out of this Agreement shall survive and continue in full force and effect in accordance with the respective terms thereof, notwithstanding any termination of this Agreement or a Termination of Executive’s employment. The parties agree that the Company would be damaged irreparably in the event any provision of Sections 3, 11 and 12 of this Agreement were not performed in accordance with its terms or were otherwise breached and that money damages would be an inadequate remedy for any such nonperformance or breach. Therefore, the Company or its successors or assigns shall be entitled in addition to other rights and remedies existing in their favor, to an injunction or injunctions to prevent any breach or threatened breach of any of such provisions and to enforce such provisions specifically (without posting a bond or other security).

23. Acknowledgement. Executive acknowledges that Executive has had the opportunity to discuss the content of this Agreement with and obtain advice from Executive’s attorney, have had sufficient time to and have carefully read and fully understood all of the provisions of this Agreement, and Executive is knowingly and voluntarily entering into this Agreement. Executive further acknowledges that Executive is obligated to become familiar with and comply at all times with all written policies of the Company.

[Signature Page to Follow]

Exhibit 10.7

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth above.

Executive Health Net, Inc.

By: /s/ Scott D. Law By: /s/ Jay Gellert
Name: Scott D. Law Name: Jay Gellert
Title: Health Care Services Title: Chief Executive Officer and
Officer President

cc: Angelee Bouchard
Karin Mayhew
Debbie J. Colia/Scott D. Law Personnel File

Exhibit 10.7

EXHIBIT A

FORM OF WAIVER AND RELEASE OF CLAIMS

This WAIVER AND RELEASE OF CLAIMS (this "Release" or "Agreement") is made and entered into by and between Health Net, Inc. and its affiliates and subsidiaries (hereinafter referred to as the "Company") and____________ (hereinafter referred to as the "Employee").

WHEREAS, the Company and Employee are entering into this Release as a condition to Employee's receipt of severance pay upon his or her termination of employment with the Company.

NOW, THEREFORE, the Company and Employee agree as follows:

1. **Termination Date.** Employee's employment with the Company shall terminate on ______________ (the "Termination Date"). Following termination of employment, Employee shall not represent to anyone that he or she is an employee of the Company and shall not say or do anything purporting to bind the Company. For purposes of this Agreement, Employee will be entitled to receive the severance payment and benefits set forth under Section 2 hereof only to the extent Employee's termination of employment constitutes a "separation from service," as defined in Treasury Regulation Section 1.409A-1(h), and, in the event that Employee's "separation from service" occurs on a date other than the date set forth above, the "Termination Date" shall mean the date of Employee's "separation from service."

2. **Severance Benefits.** Provided that Employee signs and delivers this Agreement to the Company on or before the twenty-first (21st) day after Employee's receipt of this Agreement and does not revoke his/her acceptance within seven (7) days after signing this Agreement, the Company will provide Employee with the following benefits and payments, subject to the terms and conditions set forth in this Release:

   a. Employee shall be entitled to receive a lump sum severance payment under the terms of Employee's employment agreement or an applicable Company severance policy (as in effect from time to time) in the amount of $______ (which is equal to ____ months of Employee's monthly base salary in effect as of the date set forth in Section 1), subject to withholding for payroll taxes and applicable deductions. The severance payment will be made on the regular Company payday for the first payroll period beginning after the Effective Date as defined in Section 4(d)(vi), and in no event later than March 15 following the calendar year in which the Termination Date occurs.

   In the event that the Company rehires Employee and the number of months between Employee's Termination Date and the date of his or her re-hire, if any, is less than the number of months of Employee's monthly base salary that was taken into account to calculate his or her lump sum severance payment, then the Employee shall repay to the Company an amount equal to the amount of his or her severance payment multiplied by a fraction, the numerator of which is the number of months on which the severance payment was based, minus the number of months (any partial month will be prorated) during which the Employee was unemployed by the Company, and the denominator of which is the number of months on which the severance payment was based (e.g. if an employee receives three months of severance pay and is re-hired by the Company two months after his or her Termination Date, he or she will be required to repay to the Company an amount equal to one month of severance pay.) In addition, upon re-hire the COBRA premium benefits set forth in Section 2(b) will cease when Employee becomes eligible as an employee for benefits under the Company's group health, vision and dental plans.

In further consideration for the Employee's acceptance of this Agreement, the Company will provide outplacement services to the Employee rendered by Lee Hecht Harrison per the Company's outplacement service program in effect as of the date of this Agreement. The Employee must enroll in the outplacement service program with Lee Hecht Harrison within sixty (60) days of the Employee's Termination Date in order to be eligible to receive these outplacement service benefits. To the greatest extent applicable, such outplacement services shall be provided in a manner that is exempt from Section 409A of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations and Internal Revenue Service guidance thereunder ("Section 409A") in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(A). In the event that the outplacement services constitute nonqualified deferred compensation subject to Section 409A of the Code, the outplacement services shall be provided in a manner that complies with Section 409A of the Code and the provisions of Section 19 hereof.

b. Effective as of the first day of the month immediately following the month in which the Termination Date occurs, Employee and Employee's spouse/life partner and dependents who are covered under the Company's employee welfare benefit plan which is a group health plan immediately prior to the Termination Date shall be eligible to elect to continue coverage under such plan, as required under and in accordance with Part VI ("COBRA") of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). If the appropriate COBRA election forms are completed, signed and returned by the applicable deadlines established by the Company, the Company shall pay on the Employee's behalf the full cost of the COBRA coverage for group health plan and dental and vision benefits as employee had in effect immediately prior to the Termination Date under such plan until the earlier of (i) the end of ______ months from the Termination Date and (ii) the date Employee becomes eligible for coverage under a plan of another employer. If the group health, dental or vision benefit elected by Employee is replaced or becomes unavailable, the Company will pay for coverage under the replacement benefit or, if a benefit is not replaced, the most similar plan remaining in effect. If, upon the termination of the Company's payment of such COBRA coverage, Employee continues to be entitled under federal law to receive COBRA coverage, then any such coverage shall be available to Employee, solely at Employee's expense, at the full COBRA coverage rates then in effect. COBRA election forms will be mailed to Employee's home address under separate cover. To the greatest extent applicable, such continued health coverage shall be provided in a manner that is exempt from Section 409A in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(B).

3. **Acknowledgements**.

a. Employee acknowledges and agrees that the payments and benefits set forth in Sections 2(a) and (b) above are payments and benefits to which Employee is not otherwise entitled, and Employee understands that if he or she does not sign this Release, or if he or she revokes acceptance of this Release, Employee shall not be entitled to these payments and benefits.

b. By signing below, Employee confirms and agrees that as of the Termination Date, Employee has been paid, or will be paid in his or her final regular paycheck (subject to withholding for taxes and applicable deductions), all accrued salary, unused accrued Paid Time Off, and other similar payroll related benefits and compensation due the Employee as of the Termination Date by virtue of his or her employment, in keeping with the Company's policy and practice. Employee further acknowledges that no other compensation or wages are due and owing to Employee, and no further Paid Time Off or other benefits will accrue after the Termination Date.

c. Employee's participation in all Company employee benefit plans as an active employee shall cease on the Termination Date, and Employee shall not be eligible to make contributions to or to receive additional Company contributions under the Health Net, Inc. 401(k) Associate Savings Plan, (the "401(k) Plan") (other than any "supplemental Matching Contributions" made pursuant to the 401(k) Plan) or to make any deferrals pursuant to any deferred compensation plan of the Company after the Termination Date. All payments due Employee under employee benefit plans or arrangements in which Employee participates, including without limitation, the 401 (k) Plan and any deferred compensation plan of the Company, shall be paid to Employee pursuant to the terms and provisions of such plans. Notwithstanding the foregoing, if, immediately prior to the Termination Date, Employee participates in certain Company employee welfare benefit plans, Employee's participation in such plans may continue on the same terms and conditions, including the same co-payment terms, until the last day of the month in which the Termination Date occurs.

4. **Release.**

a. *General Release*. In return for the consideration set forth in Sections 2(a) and (b) above, Employee, on behalf of himself or herself, as well as Employee's heirs, beneficiaries, successors, representatives, trustees, administrators and assigns, freely and voluntarily hereby waives and releases the Company, and each of its past, present and future officers, directors, shareholders, employees, consultants, accountants, attorneys, agents, managers, insurers, sureties, parent and sister corporations, divisions, subsidiary corporations and entities, partners, joint venturers and affiliates (and each of their respective beneficiaries, successors, representatives and assigns) and all persons acting in concert with them (collectively, "Affiliates") from any and all claims, demands, damages, debts, liabilities, controversies, obligations, actions or causes of action of any nature whatsoever, whether based on tort, statute, contract, indemnity, rescission or any other theory of recovery, and whether for compensatory, punitive, equitable or other relief, whether known, unknown, suspected or unsuspected, against the Company and/or its Affiliates, including without limitation claims which may have arisen or may in the future arise in connection with any event that occurred on or before the date of Employee's execution of this Release.

These claims include but are not limited to claims arising under federal, state and local statutory or common law, including, but not limited to the Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq. ("ADEA"); Title VII of the Civil Rights Act of 1964, as amended by the Civil Rights Act of 1991, 42 U.S.C. § 2000 et seq.; Equal Pay Act, 29 U.S.C. § 206(d); the Civil Rights Act of 1866, 42 U.S.C. § 1981; the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; the False Claims Act, 31 U.S.C. § 3729 et seq.; the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq.; the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2101 et seq.; the California Fair Employment and Housing Act, Cal. Lab. Code § 12940 et seq.; the California Equal Pay Law, Cal. Lab. Code §§ 1197.5(a),1199.5; the Moore-Brown-Roberti Family Rights Act of 1991, Cal. Gov't Code §§12945.2, 19702.3; the California WARN Act, Cal. Lab. Code § 1400 et seq.; the California Labor Code; the California Constitution; (all as amended) claims arising out of any legal restrictions on the Company's right to terminate its employees; or claims arising under state and federal whistleblower statutes to the maximum extent permitted by law. Nothing herein shall be construed to impede the employee from communicating directly with, cooperating with or providing information to any government regulator.

b. *Unknown Claims.* Employee expressly waives any right or claim of right to assert hereafter that any claim, demand, obligation and/or cause of action has, through ignorance, oversight or error, been omitted from the terms of this Release. Employee makes this waiver with full knowledge of his or her rights and with specific intent to release both his or her known and unknown claims, and therefore specifically waives his or her rights under Section 1542 of the Civil

Code of California or other similar provisions of any other applicable law (collectively, "Section 1542"), which reads as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."

Employee understands and acknowledges the significance and consequence of this Release and of such specific waiver of Section 1542, and expressly agrees that this Agreement shall be given full force and effect according to each and all of its express terms and provisions, including those relating to unknown and unsuspected claims, demands, obligations and causes of action herein above specified.

c. *Claims Not Released*. This Release does not waive rights or claims under federal or state law that Employee cannot waive by private agreement, including, but not limited to those he or she may have under Sections 2800 and 2802 of the California Labor Code, the Employee's right to file a claim for unemployment benefits, worker's compensation benefits, claims under the Fair Labor Standards Act, health insurance benefits under COBRA, or claims with regards to vested benefits under a retirement plan governed by ERISA.

d. *Review and Revocation*. In accordance with the Older Workers Benefit Protection Act, Employee acknowledges and agrees this Agreement includes a waiver and release of all claims that Employee have or may have under the ADEA. With respect to the release of claims under the ADEA, Employee acknowledges that:

(i)This Agreement is written in a manner calculated to be understood by Employee and Employee understands it.

(ii)The waiver and release of claims under the ADEA contained in this Agreement does not cover rights or claims that may arise after the date on which Employee signs this Agreement.

(iii)This Agreement provides for consideration in addition to anything of value to which Employee is already entitled.

(iv)Employee is hereby advised to consult an attorney before signing this Agreement.

(v)Employee has been granted twenty-one (21) days after receiving this Agreement to decide whether or not to sign this Agreement. If Employee signs this Agreement prior to the expiration of the twenty-one (21) day period, Employee does so voluntarily and after having had the opportunity to consult with an attorney, and Employee hereby waives the remainder of the twenty-one (21) day period.

(vi)Employee has the right to revoke this Agreement within seven (7) days of signing this Agreement, and this Agreement shall not be enforceable or effective until the eighth (8th) day after he or she signs this Agreement (the "Effective Date").

(vii)In the event this Agreement is revoked, this Agreement will be null and void in its entirety, and Employee will not be entitled to the payments and benefits provided in Section 2 of this Agreement. If Employee wishes to revoke this Agreement, Employee must deliver written notice stating his or her intent to revoke this Agreement to the Company's ________________, on or before 5:00 p.m. on the seventh (7th) day after the date on which Employee signed this Agreement.

5. **No Future Actions.** To the extent permitted by law, Employee agrees that Employee shall not encourage, cooperate in, or initiate any suit or action of any kind, or voluntarily participate in same, individually or as a representative, witness or member of a class, under contract, law or regulation, federal, state or local, pertaining to any matter related to his or her employment with the Company. Employee represents that he or she has not, to date, initiated (or caused to be initiated) any such suit or action.

Employee agrees that if he or she, or anyone purporting to act on his or her behalf or under any assignment of claims from Employee, hereafter commences any suit arising out of, based upon, or relating to any of the claims released by the Agreement or in any manner asserts against the Company and/or its Affiliates, any of the claims released hereunder, then, to the maximum extent permitted by law, Employee will pay to the

Company and/or its Affiliates, as applicable, in addition to any other damages caused to them thereby, all attorneys' fees incurred by the Company and/or its Affiliates, as applicable, in defending or otherwise responding to said suit or claim.

The foregoing shall not apply if Employee is required to participate by legal process or other requirement of applicable law, provided that Employee gives the Company notice if legal process is served on the Employee; or to any challenge by Employee to the validity of any release herein of ADEA claims or to any to suit or action brought by Employee to assert such a challenge.

Additionally, nothing in this Release precludes Employee from participating in any investigation or proceeding before any federal or state agency, or governmental body, including, but not limited to, the Equal Employment Opportunity Commission, the Securities and Exchange Commission, and/or the Department of Justice. However, while Employee may file a charge, provide information, or participate in any investigation or proceeding, by signing this Release, Employee, to the maximum extent permitted by law, waives any right to bring a lawsuit against the Company, and waives any right to any individual monetary recovery in any such proceeding or lawsuit or in any proceeding brought based on any communication by Employee to any federal, state or local government agency or department.

6. **Cooperation with the Company.** In addition, Employee shall, without further compensation, cooperate with and assist the Company in the investigation of, preparation for or defense of any actual or threatened third party claim, investigation or proceeding involving the Company or its predecessors or affiliates and arising from or relating to, in whole or in part, Employee's employment with the Company or its predecessors or affiliates for which the Company requests Employee's assistance, which cooperation and assistance shall include, but not be limited to, providing truthful testimony and assisting in information and document gathering efforts. In connection herewith, it is agreed that the Company will use its reasonable best efforts to assure that any request for such cooperation will not unduly interfere with Employee's other material business and personal obligations and commitments.

7. **Return of Company Property.** Employee agrees he or she shall return to the Company immediately upon termination of employment any building key(s), security pass or other access or identification cards and any and all Company property in his or her possession, including but not limited to any books, documents, credit cards, computer equipment, software, mobile phones or data files. Employee agrees to submit all expense accounts and to pay promptly the outstanding balance on each corporate credit card that the Company previously issued to Employee. Compliance with this Section is a condition precedent to the Company's obligation to provide the payments and benefits set forth in Section 2.

8. **Confidential Information.** To the maximum extent permitted by law, Employee shall not, without the Company's written consent by an authorized representative, at any time prior or subsequent to the execution of this Release, disclose, use, remove or copy any

Confidential Information, trade secret or proprietary information he or she acquired during the course of his or her employment by the Company. “Confidential Information,” for purposes of this Agreement, includes any information not previously published or generally in the public domain. Confidential Information, trade secrets and proprietary information includes without limitation, any technical, actuarial, economic, financial, procurement, provider, enrollee, customer, underwriting, contractual, managerial, marketing or other information of any type regarding the business in which the Company is engaged, but not including any previously published information or other information generally in the public domain. Employee also agrees that he or she shall not without the Company’s written consent by an authorized representative, directly or indirectly use the Company’s trade secret information, including but not limited to customer lists, to solicit business of any customers of the Company (other than on behalf of the Company). Employee acknowledges and agrees that any “Invention,” including without limitation, any developments or discoveries by Employee during the course of his or her employment with the Company through the date of execution of this Release resulting in patents, lists of customers, trade secrets, specialized know-how or other intellectual property useful in the then-current business of the Company and any original works of authority are the property of the Company and shall be used for the sole benefit of the Company. If not previously assigned to the Company, Employee hereby assigns ownership of any and all Inventions to the Company, provided, however, that the provisions of this Agreement requiring assignment of Inventions to the Company do not apply to any invention which qualifies fully under the provisions of California Labor Code section 2870, which provides as follows:

“(a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer’s equipment, supplies, facilities, or trade secret information except for those inventions that either:

(1) Relate at the time of conception or reduction to practice of the invention to the employer’s business, or actual or demonstrably anticipated research or development of the employer; or

(2) Result from any work performed by the employee for the employer.

(b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable.”

This provision shall supplement, but not limit or supersede any other agreement between Employee and the Company concerning any Confidential Information or other intellectual property.

9. **Non-Solicitation.** In addition to any other part or term of this Release, Employee agrees that he or she shall not, for a period of one (1) year from the date of this Agreement, regardless of the reason for Employee’s termination of employment, without the

Company's written consent by an authorized representative, on his or her own behalf or on behalf of any other person, either directly or indirectly, solicit, recruit, encourage or induce any employee, agent, provider, vendor or independent contractor with whom Employee became acquainted during the course of employment to terminate such a person's or entity's relationship with the Company or to associate with a competitor of the Company. The prohibitions of this paragraph are not intended to deny employment opportunities within the Employee's field of employment but are limited only to those prohibitions necessary to protect the Company from unfair competition.

10. **No Disparagement.** Employee further agrees and acknowledges that in exchange for the consideration identified in Sections 2 (a) and (b) above, he or she shall not make any disparaging comments and/or statements to anyone either orally or in writing about the Company and/or its employees.

11. **No Admission.** Nothing contained herein shall be construed as an admission of any wrongful act, including, but not limited to, violation of any contract, express or implied, or any federal, state or local employment laws or regulations, and nothing contained herein shall be used for any purpose except in proceedings related to the enforcement of this Release.

12. **Arbitration of Disputes.** If there is any dispute between the Company and the Employee over the terms or obligations under this Release, that dispute shall be resolved by binding arbitration before a single neutral arbitrator who shall be a retired judge. The arbitration shall proceed in accordance with the then-current Employment Rules of the American Arbitration Association. The judgment of the arbitrator shall be final, binding and nonappealable, and may be entered in any state or federal court having jurisdiction thereafter. The arbitrator shall be bound to apply and follow the applicable state or federal laws in reaching a decision in this matter. Any disagreement regarding whether a dispute is required to be arbitrated pursuant to this Release shall be decided by the arbitrator. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall govern the interpretation and enforcement of this paragraph.

Notwithstanding the above paragraph, the arbitration procedure shall not prohibit Employee or the Company from seeking injunctive relief, including without limitation, temporary or preliminary injunctive relief, through any court of competent jurisdiction if such relief is not available or is not available in a timely manner, through arbitration.

13. **Confidentiality.** Employee represents and agrees that he or she will keep the terms, amounts and facts of this Release completely confidential, and that he or she will not hereafter disclose any information concerning this Release to anyone except his or her immediate family, attorneys or accountants or taxing authorities, except as may be required by law. Employee agrees that if Employee discloses this Release to anyone in his or her immediate family, his or her attorney(s), or his or her accountant(s), Employee will ensure that the individual to whom Employee discloses the Agreement understands that he or she is also subject to this confidentiality provision. Employee agrees that he or she is liable for any breach of this provision by his or her immediate family, attorney(s)

or accountant(s), in the same manner and with the same consequences as if the Employee himself/herself had breached this provision. This provision shall not apply to any information that becomes generally known as a result of disclosure by the Company.

14. **Severability.** Should any part, term or provision of this Release be declared and/or be determined by any court or arbitrator to be illegal or invalid, the validity of the remaining parts, terms or provisions shall not be affected thereby, and said illegal or invalid part, term or provision shall be deemed not to be a part of this Release.

15. **Entire Agreement/No Oral Modification.** This Release contains the entire agreement between the parties hereto, and fully supersedes any and all prior agreements or understandings between the parties hereto pertaining to the subject matter hereof. There may be no modification of the terms of this Release except in writing signed by the parties hereto.

16. **Opportunity to Consult with Counsel.** Employee acknowledges that he or she has had an opportunity to consult with and be represented by counsel of Employee's choosing in the review of this Release, that he or she has been advised by the Company to do so, that the Employee is fully aware of the contents of the Release and of its legal effect, that the preceding paragraphs recite the sole consideration for this Release, and that Employee enters into this Release freely, without duress or coercion, and based on the Employee's own judgment and wishes and not in reliance upon any representation or promise made by the Company, other than those contained herein.

17. **Choice of Law.** Except as otherwise stated herein, this Release shall in all respects be interpreted, enforced and governed under the laws of the State of California. The language of all parts of this Release shall in all cases be construed as a whole, according to its fair meaning, and not strictly for or against any of the parties.

18. **Reformation.** In the event any part, term or provision herein is not enforceable including because its geographic scope, length or subject matter is determined to be excessive, then such part, term or provision shall be reformed to the minimum extent necessary to make such part, term or provision enforceable.

19. **Outplacement and Section 409A.** To the extent that the outplacement services provided under Section 2(a) and/or the continued health benefits payable under Section 2(b) constitute non-exempt "nonqualified deferred compensation" (within the meaning of Section 409A) that is subject to Section 409A, such benefits shall be provided in a manner that complies with the requirements of Treasury Regulation Section 1.409A-3(i)(1)(iv), including, without limitation, the following conditions: (i) the benefits payable in Employee's taxable year may not affect such benefits that Employee is eligible to receive in another taxable year of Employee; (ii) the reimbursement of expenses or provision of in-kind benefits shall be made on or before the last day of Employee's taxable year following the taxable year in which the expense or obligation is incurred; and (iii) such benefits shall not be subject to liquidation or exchange for another benefit.

20. **Headings.** The headings of the Sections of this Agreement are provided for convenience only. They do not alter or limit, in any way, the text of any Section of this Agreement.

21. **Acceptance and Expiration.** Employee has up to twenty-one (21) calendar days from the date he or she receives this document to consider and accept the terms of this Release, but may accept it at any time within those twenty-one (21) calendar days. Employee agrees that changes to the terms or form of this Release, whether material or immaterial do not restart the running of the twenty-one (21) day period. After twenty-one (21) calendar days have passed, this offer will expire.

Exhibit 10.7

EMPLOYEE ACKNOWLEDGES BY SIGNING BELOW that (i) Employee has not relied upon any representations, written or oral, not set forth in this Release; (ii) at the time Employee was given this Release, Employee was informed in writing by the Company that: (a) Employee had at least twenty-one (21) calendar days in which to consider whether Employee would sign the Release; (b) Employee was advised to consult with an attorney before signing the Release; and (c) Employee had seven (7) calendar days to revoke this Agreement after signing it; (iii) Employee had an opportunity to consult with an attorney and either had such consultations or has freely decided to sign this Release without consulting an attorney; and (iv) Employee executes this Release knowingly and voluntarily.

IN WITNESS WHEREOF, the parties hereto have executed this Release as of the dates set forth below.

Employee Health Net, Inc.

By: By: ______________________________
Name: Name:
Title:

Dated: Dated: ______________________________

NOTE: Please return your signed waiver and release to:
Organization Effectiveness Unit
Attention: (Name, Title)
(Address, City, State, Zip Code)

Exhibit 10.9

AMENDED AND RESTATED EMPLOYMENT AGREEMENT

This AMENDED AND RESTATED EMPLOYMENT AGREEMENT (this “Agreement”) is made and entered into as of February 24, 2015, by and between Health Net, Inc., a Delaware corporation (the “Company”), with its principal place of business located at 21650 Oxnard Street, Woodland Hills, California 91367, and Steven Sell (“Executive”). This Agreement amends and restates in its entirety the Prior Agreement (as defined below).

RECITALS

WHEREAS, the Company and Executive previously entered into that certain Amended and Restated Employment Agreement dated February 22, 2010 (the “Prior Agreement”); and

WHEREAS, the Company and Executive desire to amend and restate the Prior Agreement on the terms and conditions set forth herein, and to supersede the Prior Agreement in all respects effective as of October 9, 2014 (the “Effective Date”).

NOW, THEREFORE, in consideration of the following covenants, conditions and promises contained herein, and other good and valuable consideration, the Company and Executive hereby agree as follows:

1. Duties and Salary.

A. Duties. Executive’s title is President, Western Region Health Plans, but may be changed at the discretion of the Company to a title that reflects a similarly situated senior executive position. Executive shall report directly to Jim Woys, Executive Vice President, Chief Financial and Operating Officer and Interim Treasurer of the Company, but Executive’s reporting relationship may be changed from time to time at the discretion of the Company. Executive’s duties and responsibilities include responsibility for the strategic direction, leadership, revenue growth and profitability of the Company’s Commercial and Medicare businesses in Arizona, California, Oregon and Washington. Executive’s duties and responsibilities also include serving as President of Health Net of California, having oversight of the Company’s enterprise-wide marketing function, and establishing and executing strategic direction in matters of financial performance, sales, marketing and business development, operations and organization effectiveness. However, the Company reserves the right to assign Executive other duties as needed and to change Executive’s duties from time to time on reasonable notice, based on Executive’s skills and the needs of the Company. In the event that Executive performs any such additional duties, Executive shall not be entitled to an increase in compensation beyond that specified in this Agreement.

B. Salary. As of February 21, 2015, Executive will be paid a base salary at the annual rate of $557,304 which salary will be paid on a pro-rated bi-weekly basis, less applicable withholdings (“Base Salary”), covering all hours worked. Generally, Executive’s Base Salary will be reviewed annually, but the Company reserves the right to change Executive’s compensation from time-to-time. Pursuant to the charter of the Compensation Committee of the Company’s Board of Directors (the “Committee”), any adjustment to Executive’s compensation must be made with the approval of the Committee and, in the event that Executive constitutes one of the top two (2) highest paid executive officers of the Company, with the ratification of the Company’s Board of Directors.

C. Disclosure of Personal Compensation Information. As an “executive officer” of the Company (as such term is defined in the rules and regulations of the Securities and Exchange Commission (“SEC”)), information regarding Executive’s employment arrangements with the Company, including, among other things, the terms of this Agreement and any stock option agreement, restricted stock agreement, restricted stock unit agreement, performance share agreement and/or severance agreement Executive enters into with the Company from time to time (collectively, “Personal Compensation Information”), may be disclosed in filings with the SEC, the New York Stock Exchange (“NYSE”) and/or other regulatory organizations upon the occurrence of certain triggering events. Such triggering events include, but are not limited to, the execution of this Agreement and any amendments thereto, changes in Executive’s Base Salary, any annual incentive payment (whether in the form of cash or equity) awarded to Executive (in the past or after the date hereof), and the establishment of performance goals under the Company’s incentive plans. Executive’s execution of this Agreement will serve as Executive’s acknowledgement that

Executive's Personal Compensation Information may be publicly disclosed from time to time in filings with the SEC, NYSE or otherwise as necessary.

2. Adjustments and Changes in Employment Status. Executive understands that the Company reserves the right to make personnel decisions regarding Executive's employment, including, but not limited to, decisions regarding any promotion, salary adjustment, transfer or disciplinary action, up to and including Termination (as defined below), consistent with the needs of the business of the Company.

For purposes of this Agreement, the capitalized terms "Termination" and "Terminate," shall mean Executive's Separation from Service (as defined below) from the Company. A "Separation from Service" with respect to Executive shall mean a "separation from service," as defined in Treasury Regulation Section 1.409A-1(h) or any regulation that supersedes such regulation.

3. Protection of Proprietary and Confidential Information. Executive agrees that Executive's employment creates a relationship of confidence and trust with the Company with respect to Proprietary and Confidential Information (as defined below) of the Company learned by Executive during Executive's employment.

A. Executive agrees not to directly or indirectly use or disclose any of the Proprietary and Confidential Information of the Company or any of its affiliates at any time except in connection with the services Executive provides to such entities. "Proprietary and Confidential Information" shall mean trade secrets, confidential knowledge, data or any other proprietary or confidential information of the Company or any of its affiliates, or of any customers, members, employees or directors of any of such entities, but shall not include any information that (i) was publicly known and made generally available in the public domain prior to the time of disclosure to Executive by the Company or (ii) becomes publicly known and made generally available after disclosure to Executive by the Company other than as a result of a disclosure by Executive in violation of this Agreement. By way of illustration but not limitation, "Proprietary and Confidential Information" includes: (i) trade secrets, documents, memoranda, reports, files, correspondence, lists and other written and graphic records affecting or relating to any such entity's business; (ii) confidential marketing information including without limitation marketing strategies, customer and client names and requirements, services, prices, margins and costs; (iii) confidential financial information; (iv) personnel information (including without limitation employee compensation); and (v) other confidential business information.

B. Executive further agrees that at all times during Executive's employment and thereafter, Executive will keep in confidence and trust all Proprietary and Confidential Information, and that Executive will not use or disclose any Proprietary and Confidential Information or anything related to such information without the written consent of the Company, except as may be necessary in the ordinary course of performing Executive's duties to the Company.

C. All Company property, including, but not limited to, Proprietary and Confidential Information, documents, data, records, apparatus, equipment and other physical property, whether or not pertaining to Proprietary and Confidential Information, provided to Executive by the Company or any of its affiliates or produced by Executive or others in connection with Executive's providing services to the Company or any of its affiliates shall be and remain the sole property of the Company or its affiliates (as the case may be) and shall be returned promptly to such appropriate entity as and when requested by such entity. Executive shall return and deliver all such property upon termination of Executive's employment, and Executive may not take any such property or any reproduction of such property upon such termination.

D. Executive recognizes that the Company and its affiliates have received and in the future will receive information from third parties which is private, proprietary or confidential information subject to a duty on such entity's part to maintain the confidentiality of such information and to use it only for certain limited purposes. Executive agrees that during Executive's employment, and thereafter, Executive owes such entities and such third parties a duty to hold all such private, proprietary or confidential information received from third parties in the strictest confidence and not to disclose it, except as necessary in carrying out Executive's work for such entities consistent with such entities' agreements with such third parties, and not to use it for the benefit of anyone other than for such entities or such third parties consistent with such entities' agreements with such third parties.

E. Executive's obligations under this Section 3 shall continue after the Termination of Executive's employment and any breach of this Section 3 shall be a material breach of this Agreement.

4. Physical Exam. Executive shall be required, on an annual basis, to undergo a physical examination and to send evidence that Executive has undergone such exam (but in no case the results of such exam) to the Senior Vice President of Organization Effectiveness. The Company shall reimburse Executive for any out-of-pocket expenses relating to the physical examination that are not otherwise covered by Executive's health insurance plan.

5. Representations and Warranties of Executive.

A. No Violation; No Conflicts. Executive represents and warrants to the Company that the entering into of this Agreement and Executive's performance of Executive's duties hereunder, will not violate any agreements with, or trade secrets of, any other person or entity. Executive further represents and warrants that Executive does not have any relationship or commitment to any other person or entity that might be in conflict with Executive's obligations to the Company under this Agreement, including but not limited to outside employment, sales broker relationships, investments or business activities. Executive understands and agrees that while employed by the Company Executive is expected to refrain from engaging in any outside activities that might be in conflict with the business interests of the Company. In addition, Executive represents and warrants to the Company that Executive has not shared with or disclosed to, and will not share with or disclose to, the Company any proprietary or confidential information of Executive's previous employers or any other third party.

B. Legal Proceedings. Executive represents and warrants to the Company that Executive has not been arrested, indicted, convicted or otherwise involved in any criminal or civil action or legal matter that could affect Executive's ability to perform Executive's duties hereunder or that may have a negative impact on the Company, its reputation or its operations. Executive agrees, to the extent permitted by applicable law, to notify the Company's Senior Vice President of Organization Effectiveness immediately in the event that Executive becomes party to any criminal or civil action or other legal matter in the future that could have an affect on the foregoing representation.

6. Executive Benefits.

A. Employee Benefit Programs. Executive shall be eligible to participate in the Company's various employee benefit programs and plans in place from time to time in accordance with their terms, as long as Executive remains employed by the Company and Executive meets the applicable participation requirements. These benefit programs and plans currently include paid time off ("PTO"), holidays, group medical, dental, vision, term life, and short and long term disability insurance and participation in the Company's 401(k) plan, tuition reimbursement plan and deferred compensation plan. The Company or its subsidiaries or affiliates may modify, terminate or amend any benefit or plan in its discretion, retroactively or prospectively, subject only to applicable law.

B. Required Insurance. Executive will be covered by workers' compensation insurance and state disability insurance, as required by state law.

C. Fringe Benefits. Executive will be entitled to such fringe benefits and perquisites as are provided by the Company from time to time, in accordance with the Company's policies, practices and procedures, and shall receive such additional fringe benefits and perquisites as the Company may, in its discretion, from time-to-time provide. Without limiting the generality of the foregoing, Executive will be entitled to (i) be reimbursed up to the amount of $5,000 per year for documented costs incurred for personal financial counseling services provided to Executive, including tax preparation, and (ii) receive a $1,000 per month car allowance (a grandfathered benefit), in each case, as long as Executive remains employed by the Company. The Company or its subsidiaries or affiliates may modify, terminate or amend any fringe benefit or perquisite in its discretion, retroactively or prospectively, subject only to applicable law.

D. Incentive Bonus. Executive will be eligible to participate in the Health Net, Inc. Management Incentive Plan, or such other Company bonus plan that may be in effect from time to time, in accordance with the terms of such plan, which provides Executive with a target bonus for each plan year equal to 80% of Executive's Base Salary as additional compensation according to the terms of such plan. The actual bonus payment will range from 0% to 200% of target depending upon the actual results achieved. It is understood that the Committee and the

Company will award bonus amounts, if any, as it deems appropriate consistent with the MIP or such other bonus plan that may be in effect from time to time.

E. Expenses. Subject to and in accordance with the Company's written policies for business and travel expenses, Executive will receive reimbursement for all business travel and other out-of-pocket expenses reasonably incurred by Executive in the performance of Executive's duties pursuant to this Agreement.

7. Equity Grants; Stock Ownership Requirement.

A. Future Equity Grants. Any future equity grants made to Executive will be granted under one of the Company's Long-Term Incentive Plans, and will be subject to the terms of such plan and of the agreement executed in connection with such grant. Any future equity grants to Executive will be made at the discretion of the Committee.

B. Company Stock Ownership Requirement. In accordance with the Executive Officer Stock Ownership Policy adopted by the Board of Directors of the Company, as may be amended from time to time (the "Executive Stock Ownership Policy"), Executive is currently required to own "Qualifying Shareholdings" (as defined in the Executive Stock Ownership Policy) having a value of one time (1x) Executive's Base Salary in effect from time to time pursuant to this Agreement (the "Stock Ownership Requirement"). The number of Qualifying Shareholdings Executive is required to own will be calculated based on the average NYSE closing price per share of the Company's Common Stock (as adjusted for stock splits and similar changes to the Common Stock) for the most recently completed fiscal year of the Company.

Using Executive's Base Salary as of February 21, 2015, which was $557,304, and a stock price of $41.04, which was the average closing price per share of the Company's Common Stock for the fiscal year ended December 31, 2014, Executive's Stock Ownership Requirement as of February 21, 2015 was 13,580 shares ("Target Amount"). The Target Amount is subject to change from time to time based on (1) changes in the average closing price per share of the Company's Common Stock on an annual basis, (2) any changes in Executive's Base Salary made pursuant to and in accordance with Section 1(B) of this Agreement, and (3) any changes under the terms of the Executive Stock Ownership Policy.

Under the Executive Stock Ownership Policy as currently in effect, to the extent that Executive has not achieved the Stock Ownership Requirement, Executive must hold 75% of all "net settled shares" received from the vesting, delivery or exercise of equity awards granted under the Company's equity award (including long-term incentive) plans, as such term is defined in the Executive Stock Ownership Policy.

The Committee expects that Executive will make reasonable progress toward Executive's Stock Ownership Requirement. Executive will be notified on an annual basis of any changes in Executive's Target Amount.

8. Term of Employment. Executive's employment with the Company is at the mutual consent of Executive and the Company. Nothing in this Agreement is intended to guarantee Executive's continuing employment with the Company or employment for any specific length of time. Accordingly, either Executive or the Company may terminate the employment relationship at any time and for any reason whatsoever (or for no reason), subject to certain notice requirements, to the extent applicable, as set forth herein. Upon Termination of Executive's employment for any reason, in addition to any other payments that may be payable to Executive hereunder, Executive (or Executive's beneficiaries or estate) shall be paid (in each case to the extent not theretofore paid) within thirty (30) days following Executive's date of Termination (or such shorter period that may be required by applicable law): (a) Executive's annual Base Salary through such Termination date, (b) accrued but unused PTO, (c) reimbursable expenses incurred by Executive prior to the Termination date and (d) amounts to which Executive may be entitled through such Termination date under any other compensatory plan, arrangement or program payment in accordance with the terms thereunder. This Agreement constitutes a final and fully binding integrated agreement with respect to the at-will nature of the employment relationship.

9. Termination of Employment/Severance Pay.

A. Termination Without Cause Not Following Change in Control. If Executive's employment is Terminated by the Company without "Cause" (as defined in Section 9(D) below) at any time that is not within two

Exhibit 10.9

(2) years after a “Change in Control” (as defined below) of Health Net, Inc., Executive will be entitled to receive, within thirty (30) days following the Termination of Executive’s employment, provided that Executive signs and delivers prior to the expiration of such (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) a lump sum cash payment equal to twelve (12) months of Executive’s Base Salary in effect immediately prior to the date of Executive’s Termination, and (ii) the continuation, under COBRA, of Executive’s medical, dental and vision benefits (as maintained for Executive’s benefit immediately prior to the date of Executive’s Termination) (the “Benefits”) for Executive and Executive’s dependents for a period of twelve (12) months following the effective date of Executive’s Termination, with premium payments paid by the Company on Executive’s behalf as they become due, provided, that Executive properly elects to continue those benefits under COBRA.

For purposes of this Agreement, “Change in Control” is defined as any of the following which occurs subsequent to the Effective Date:

(i) Any person (as such term is defined under Section 13(d)(3) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”)), corporation or other entity (other than Health Net, Inc. or any of its subsidiaries, or any employee benefit plan sponsored by Health Net, Inc. or any of its subsidiaries) is or becomes the beneficial owner (as such term is defined in Rule 13d-3 under the Exchange Act) of securities of Health Net, Inc. representing twenty percent (20%) or more of the combined voting power of the outstanding securities of Health Net, Inc. which ordinarily (and apart from rights accruing under special circumstances) have the right to vote in the election of directors (calculated as provided in paragraph (d) of such Rule 13d-3 in the case of rights to acquire Health Net, Inc.’s securities) (the “Securities”);

(ii) As a result of a tender offer, merger, sale of assets or other major transaction, the persons who are directors of Health Net, Inc. immediately prior to such transaction cease to constitute a majority of the Board of Directors of Health Net, Inc. (or any successor corporations) immediately after such transaction;

(iii) Health Net, Inc. is merged or consolidated with any other person, firm, corporation or other entity and, as a result, the shareholders of Health Net, Inc., as determined immediately before such transaction, own less than eighty percent (80%) of the outstanding Securities of the surviving or resulting entity immediately after such transaction:

(iv) A tender offer or exchange offer is made and consummated for the ownership of twenty percent (20%) or more of the outstanding Securities of Health Net, Inc.;

(v) Health Net, Inc. transfers substantially all of its assets to another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc.; or

(vi) Health Net, Inc. enters into a management agreement with another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc. and such management agreement extends hiring and firing authority over Executive to an individual or organization other than Health Net, Inc.

B. Termination Without Cause or For Good Reason Following Change in Control. If at any time within two (2) years after a Change in Control of Health Net, Inc. Executive’s employment is Terminated by the Company without Cause or Executive Terminates Executive’s employment for “Good Reason” (as defined below) (by giving the Company at least fourteen (14) days prior written notice of the effective date of Termination), then Executive will be entitled to receive, within thirty (30) days following the Termination of Executive’s employment, provided that Executive signs and delivers prior to the expiration of such thirty (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) a lump sum payment equal to twenty-four (24) months of Executive’s Base Salary in effect immediately prior to the date of Executive’s Termination, and (ii) the continuation of Executive’s Benefits for six (6) months following Executive’s date of Termination, and (iii) and after expiration of such six (6) months Benefits continuation period, the continuation, under COBRA, of Benefits for Executive and Executive’s dependents for an additional period of eighteen (18) months following the effective date of Executive’s Termination with premium payments made by the Company on Executive’s behalf, provided, that Executive properly elects to continue those benefits under COBRA, and provided, further, that in the event the Company requests, in writing, prior to such voluntary Termination by

Executive for Good Reason that Executive continue in the employ of the Company for a period of time up to 90 days following such Change in Control, then Executive shall forfeit such severance allowance if Executive voluntarily leaves the employ of the Company prior to the expiration of such period of time.

For purposes of this Agreement, the term "Good Reason" means any of the following which occurs, without Executive's consent, subsequent to the effective date of a Change in Control as defined above:

(i) A substantial reduction in the scope of Executive's authority, duties or responsibilities with the Company, except in connection with the Termination of Executive's employment for Disability (as defined below), normal retirement or Cause or by Executive voluntarily other than for Good Reason;

(ii) A material reduction by the Company in Executive's base compensation (*i.e.*, Executive's Base Salary and/or target annual bonus) as in effect immediately prior to any such reduction;

(iii) A relocation of Executive to a work location more than fifty (50) miles from Executive's work location immediately prior to such proposed relocation; provided that such proposed relocation results in a materially greater commute for Executive based on Executive's residence immediately prior to such relocation; or

(iv) The failure of the Company to obtain an assumption agreement from any successor contemplated under Section 12 of this Agreement;

provided, however, that (a) Executive provides written notice to the Company of the existence of the condition described above within ninety (90) days of the initial existence of the condition, (b) the Company fails to cure such condition within thirty (30) days after receipt of such written notice, and (c) the date of Executive's Termination occurs no later than seventy-five (75) days after the initial occurrence of the event constituting Good Reason, in accordance with Treasury Regulation Section 1.409A-1(n)(2)(ii).

C. Voluntary Termination. Notwithstanding anything to the contrary in this Agreement, whether express or implied, Executive may at any time Terminate Executive's employment for any reason by giving the Company fourteen (14) days prior written notice of the effective date of Termination. In the event that Executive voluntarily Terminates employment with the Company (except for Good Reason within two (2) years after a Change in Control of Health Net, Inc., as described in Section 9(B) hereof), then Executive shall not be eligible to receive any payments or continuation of Benefits set forth in this Section 9.

D. Termination by the Company for Cause. The Company may Terminate Executive's employment for "Cause" at any time with or without advance notice. In the event of such Termination, Executive will not be eligible to receive any of the payments set forth in Section 9(A) or 9(B) above. For purposes of this Agreement, a Termination for "Cause" is defined as: (i) an act of dishonesty causing harm to the Company or any of its affiliates, (ii) the material breach of either the Company's Code of Business Conduct and Ethics (the "Code of Conduct") or any policy or procedure developed and published by the Company regarding compliance or ethics related to the Code of Conduct, (iii) habitual drunkenness or narcotic drug addiction, (iv) conviction of, or entry by Executive of a guilty or no contest plea to, the commission of a felony or a misdemeanor involving moral turpitude, (v) willful refusal to perform or gross neglect of the duties assigned to Executive, (vi) the willful breach of any law that, directly or indirectly, affects the Company or any of its affiliates, (vii) a material breach by Executive following a Change in Control of those duties and responsibilities of Executive that do not differ in any material respect from Executive's duties and responsibilities during the 90-day period immediately prior to such Change in Control (other than as a result of incapacity due to physical or mental illness) which is demonstrably willful and deliberate on Executive's part, which is committed in bad faith or without reasonable belief that such breach is in the best interests of the Company or any of its affiliates and which is not remedied in a reasonable period of time after receipt of written notice from the Company specifying such breach, or (viii) breach of Executive's obligations hereunder (or under any Company policy) to protect the proprietary and confidential information of the Company or any of its affiliates.

E. Termination Due to Death or Disability. In the event that Executive's employment is Terminated at any time due to Executive's death or "Disability" (as defined below), Executive (or Executive's beneficiaries or estate) shall be entitled to receive, provided Executive (or Executive's beneficiaries or estate, as applicable) signs a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) continuation of Executive's

Benefits for a period of twelve (12) months from the date of Termination and (ii) a lump sum payment equal to twelve (12) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, to be paid within thirty (30) days following Executive's Termination of employment. For purposes of this Agreement, a Termination for "Disability" shall mean a Termination of Executive's employment due to Executive's absence from Executive's duties with the Company on a full-time basis for at least 180 consecutive days as a result of Executive's incapacity due to physical or mental illness which is determined to be total and permanent by a physician selected by the Company or its insurers.

10. Withholding. All payments required to be made by the Company hereunder to Executive or Executive's estate or beneficiaries shall be subject to the withholding of such amounts relating to taxes as the Company may reasonably determine should be withheld pursuant to any applicable law or regulation.

11. Restrictive Covenants.

A. Non-Competition. Executive hereby agrees that, during (i) the six (6)-month period following a Termination of Executive's employment with the Company that entitles Executive to receive severance benefits under this Agreement or a written agreement with or policy of the Company or (ii) the twelve (12)-month period following a Termination of Executive's employment with the Company that does not entitle Executive to receive such severance benefits (the period referred to in either clause (i) or (ii), the "Restricted Period"), Executive shall not undertake any employment or activity (including, but not limited to, consulting services) with a Competitor (as defined below) in any geographic area in which the Company or any of its affiliates operate (the "Market Area"), where the loyal and complete fulfillment of the duties of the competitive employment or activity would call upon Executive to reveal, to make judgments on or otherwise use or disclose any confidential business information or trade secrets of the business of the Company or any of its affiliates to which Executive had access during Executive's employment with the Company. For purposes of this Section, "Competitor" shall refer to any health maintenance organization or insurance company that provides managed health care or related services similar to those provided by the Company or any of its affiliates.

B. Non-Solicitation. In addition, Executive agrees that, during the applicable Restricted Period following Termination of Executive's employment with the Company, Executive shall not, directly or indirectly, (i) solicit, interfere with, hire, offer to hire or induce any person, who is or was an employee of the Company or any of its affiliates at the time of such solicitation, interference, hiring, offering to hire or inducement, to discontinue his/her relationship with the Company or any of its affiliates or to accept employment by, or enter into a business relationship with, Executive or any other entity or person or (ii) solicit, interfere with or otherwise contact any customer or client of the Company or any of its affiliates.

C. Modification of Restrictions. It is hereby further agreed that if any court of competent jurisdiction shall determine that the restrictions imposed in this Section 11 are unreasonable (including, but not limited to, the definition of Market Area or Competitor or the time period during which this provision is applicable), the parties hereto hereby agree to any restrictions that such court would find to be reasonable under the circumstances.

D. Injunction Rights. Executive also acknowledges that the services to be rendered by Executive to the Company are of a special and unique character, which gives this Agreement a peculiar value to the Company or any of its affiliates, the loss of which may not be reasonably or adequately compensated for by damages in an action at law, and that a material breach or threatened breach by Executive of any of the provisions contained in this Section 11 will cause the Company or any of its affiliates irreparable injury. Executive therefore agrees that the Company may be entitled, in addition to the remedies set forth above in this Section 11 and any other right or remedy, to a temporary, preliminary and permanent injunction, without the necessity of proving the inadequacy of monetary damages or the posting of any bond or security, enjoining or restraining Executive from any such violation or threatened violations.

12. Successors; Binding Agreement.

A. Survival Following Merger, Consolidation or Asset Transfer. This Agreement shall not be terminated by any merger or consolidation of the Company whereby the Company is or is not the surviving or resulting corporation or as a result of any transfer of all or substantially all of the assets of the Company. In the event of any such merger, consolidation or transfer of assets, the provisions of this Agreement shall be binding upon the surviving or resulting corporation or the person or entity to which such assets are transferred.

B. Survivor's Assumption of Agreement. The Company agrees that concurrently with any merger, consolidation or transfer of assets referred to in this Section 12, it will cause any successor or transferee to unconditionally assume, by written instrument delivered to Executive (or Executive's beneficiary or estate), all of the obligations of the Company hereunder. Failure of the Company to obtain such assumption prior to the effectiveness of any such merger, consolidation or transfer of assets shall entitle Executive to compensation and other benefits from the Company in the same amount and on the same terms as Executive would be entitled hereunder if Executive's employment were Terminated without Cause. For purposes of implementing the foregoing, the date on which any such merger, consolidation or transfer becomes effective shall be deemed the date of Termination.

C. Enforceability. This Agreement shall inure to the benefit of and be enforceable by Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees. If Executive shall die while any amounts would be payable to Executive hereunder had Executive continued to live, all such amounts, unless otherwise provided herein, shall be paid in accordance with the terms of this Agreement to such person or persons appointed in writing by Executive to receive such amounts or, if no person is so appointed, to Executive's estate.

13. Limitation on Payments.

A. Notwithstanding any other provisions of this Agreement, in the event that any payment or benefit received or to be received by Executive (including any payment or benefit received in connection with a Change in Control or the termination of Executive's employment, whether pursuant to the terms of this Agreement or any other plan, arrangement or agreement) (all such payments and benefits, including the payments and benefits under Section 9 hereof, being hereinafter referred to as the "Total Payments") would be subject (in whole or part), to the excise tax imposed under Section 4999 of the Internal Revenue Code of 1986, as amended (the "Code") (the "Excise Tax"), then, after taking into account any reduction in the Total Payments provided by reason of Section 280G of the Code in such other plan, arrangement or agreement, the cash severance payments shall first be reduced, and the non-cash severance payments shall thereafter be reduced, to the extent necessary so that no portion of the Total Payments is subject to the Excise Tax, but only if (i) the net amount of such Total Payments, as so reduced (and after subtracting the net amount of federal, state and local income taxes on such reduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such reduced Total Payments), is greater than or equal to (ii) the net amount of such Total Payments without such reduction (but after subtracting the net amount of federal, state and local income taxes on such Total Payments and the amount of Excise Tax to which Executive would be subject in respect of such unreduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such unreduced Total Payments). The Total Payments shall be reduced by the Company in its reasonable discretion in the following order: (A) reduction of any cash severance payments otherwise payable to Executive that are exempt from Section 409A (as defined below), (B) reduction of any other cash payments or benefits otherwise payable to Executive that are exempt from Section 409A, but excluding any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A, (C) reduction of any other payments or benefits otherwise payable to Executive on a pro-rata basis or such other manner that complies with Section 409A, but excluding any payments attributable to the acceleration of vesting and payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A, and (D) reduction of any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A.

B. For purposes of determining whether and the extent to which the Total Payments will be subject to the Excise Tax, (i) no portion of the Total Payments the receipt or enjoyment of which Executive shall have waived at such time and in such manner as not to constitute a "payment" within the meaning of Section 280G(b) of the Code shall be taken into account, (ii) no portion of the Total Payments shall be taken into account which, in the written opinion of independent auditors of nationally recognized standing ("Independent Advisors") selected by the

Company, does not constitute a "parachute payment" within the meaning of Section 280G(b)(2) of the Code (including by reason of Section 280G (b)(4)(A) of the Code) and, in calculating the Excise Tax, no portion of such Total Payments shall be taken into account which, in the opinion of Independent Advisors, constitutes reasonable compensation for services actually rendered, within the meaning of Section 280G(b)(4)(B) of the Code, in excess of the "base amount" (as defined in Section 280G(b)(3) of the Code) allocable to such reasonable compensation, and (iii) the value of any non-cash benefit or any deferred payment or benefit included in the Total Payments shall be determined by the Independent Advisors in accordance with the principles of Sections 280G(d)(3) and (4) of the Code.

14. Section 409A of the Internal Revenue Code. It is the intention of the Company and Executive that this Agreement not result in unfavorable tax consequences to Executive under Section 409A of the Code, and the Treasury Regulations and Internal Revenue Service guidance promulgated thereunder ("Section 409A") and the Agreement shall be interpreted, construed and administered as to so comply with, or be exempt from, Section 409A. Notwithstanding anything to the contrary herein, the Company and Executive agree to the provisions set forth in this Section 14 in order to comply with, or be exempt from, the requirements of Section 409A

A. If Executive is a "specified employee" (as determined under the Company's Specified Employee Policy as in effect from time to time, or, in the absence of such policy, within the meaning of Section 409A) with respect to the Company, any non-exempt non-qualified deferred compensation that is subject to Section 409A and otherwise payable to or in respect of Executive in connection with Executive's Separation from Service pursuant to this Agreement shall be delayed until the earlier of (i) the expiration of six (6) months measured from the date of Executive's Separation from Service, or (ii) the date of Executive's death. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

B. All incentive bonus payments described in Section 6(D) shall be paid to Executive, to the extent earned, in no event later than the last day of the "applicable 2-1/2 month period", as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

C. With respect to the Company's reimbursement obligations under Sections 6(C) and 6(E) hereof and the provision of Benefits to Executive, (i) in no event shall any such reimbursements or in-kind benefits be made or provided later than the last day of Executive's taxable year following the taxable year in which the fee or expense was incurred, (ii) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during Executive's taxable year may not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year of Executive, and (iii) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit, in accordance with Treasury Regulation Section 1.409A-3(i)(1)(iv).

D. The Company and Executive agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by Executive due to any failure to comply with Section 409A. To the extent payments and benefits under this Agreement are subject to Section 409A, and such payments and benefits do not so comply, the Company shall amend this Agreement, or take such other actions as the Company deems reasonably necessary or appropriate, to comply with Section 409A. If any provision of the Agreement would cause such payments and benefits to fail to so comply, such provision shall not be effective and shall be null and void with respect to such payments or benefits, and such provision shall otherwise remain in full force and effect.

15. Company Policies. Executive's employment with the Company is subject to the terms and conditions contained in the Company's Associate Policies, including those located on HR Link, which can be accessed through the Company's intranet site, as in effect from time to time (the "Associate Policies"), the content of which is incorporated by reference herein. Executive shall be required to read, understand and comply with the Associate Policies.

16. Compensation Recovery (Clawback). Notwithstanding anything in this Agreement to the contrary, any compensation payable to Executive under this Agreement that constitutes "Incentive Compensation" (as such term is defined under the Company's Compensation Recovery Policy, as such policy may be amended from time to time

Exhibit 10.9

(the “Compensation Recovery Policy”)) shall be subject to the terms and conditions of the Compensation Recovery Policy.

17. Severability. If any term of this Agreement is held to be invalid, void or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected and the parties shall use their best efforts to find an alternative way to achieve the same result.

18. Integrated Agreement. This Agreement supersedes any prior agreements, representations or promises of any kind, whether written, oral, express or implied between the parties hereto with respect to the subject matters herein, including the Prior Agreement. It constitutes the full, complete and exclusive agreement between Executive and the Company with respect to the subject matters herein. This Agreement cannot be changed unless in writing, signed by Executive and a duly authorized officer of the Company and approved by the Board of Directors of the Company (or the Committee or its delegate, if permitted by the Committee’s charter). The Company acknowledges and agrees that nothing contained herein shall be deemed to supercede, amend or otherwise modify the terms of the Indemnification Agreement dated December 14, 2009 between Executive and the Company.

19. Waiver. No waiver of any default hereunder shall operate as a waiver of any subsequent default. Failure by either party to enforce any of the terms or conditions of this Agreement, for any length of time or from time to time, shall not be deemed to waive or decrease the rights of such party to insist thereafter upon strict performance by the other party.

20. Notices. All notices and communications required or permitted hereunder shall be in writing and shall be deemed given (a) if delivered personally, (b) upon confirmation of receipt by the sender after being sent by electronic mail, (c) one (1) business day after being sent by Federal Express or a similar commercial overnight service, or (d) three (3) business days after being mailed by registered or certified mail, return receipt requested, prepaid and addressed to the following addresses, or at such other addresses as the parties may designate by written notice in the manner aforesaid:

If to the Company:	Health Net, Inc. 21650 Oxnard Street, 22nd Floor Woodland Hills, CA 91367 Attention: General Counsel
If to Executive:	Steven Sell **[ADDRESS]** **[ADDRESS]**

21. Governing Law. The interpretation, construction and performance of this Agreement shall be governed by and construed and enforced in accordance with the internal laws of the State of Delaware without regard to the principle of conflicts of laws. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provisions of this Agreement, which other provisions shall remain in full force and effect.

22. Survival and Enforcement. Sections 3, 8, 9, 11, 12, 13, 14 and 16 of this Agreement and any rights and remedies arising out of this Agreement shall survive and continue in full force and effect in accordance with the respective terms thereof, notwithstanding any termination of this Agreement or a Termination of Executive’s employment. The parties agree that the Company would be damaged irreparably in the event any provision of Sections 3, 11, and 12 of this Agreement were not performed in accordance with its terms or were otherwise breached and that money damages would be an inadequate remedy for any such nonperformance or breach. Therefore, the Company or its successors or assigns shall be entitled in addition to other rights and remedies existing in their favor, to an injunction or injunctions to prevent any breach or threatened breach of any of such provisions and to enforce such provisions specifically (without posting a bond or other security).

23. Acknowledgement. Executive acknowledges that Executive has had the opportunity to discuss the content of this Agreement with and obtain advice from Executive's attorney, have had sufficient time to and have carefully read and fully understood all of the provisions of this Agreement, and Executive is knowingly and voluntarily entering into this Agreement. Executive further acknowledges that Executive is obligated to become familiar with and comply at all times with all written policies of the Company.

[Signature Page to Follow]

Exhibit 10.9

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth above.

Executive		**Health Net, Inc.**	
By:	/s/ Steven Sell	By:	/s/ Jay Gellert
Name:	Steven Sell	Name:	Jay Gellert
Title:	President, Western Region Health Plans	Title:	Chief Executive Officer and President

cc: Angelee F. Bouchard
Karin D. Mayhew
Personnel File

Exhibit 10.9

EXHIBIT A

FORM OF WAIVER AND RELEASE OF CLAIMS

This WAIVER AND RELEASE OF CLAIMS (this "Release" or "Agreement") is made and entered into by and between Health Net, Inc. and its affiliates and subsidiaries (hereinafter referred to as the "Company") and____________ (hereinafter referred to as the "Employee").

WHEREAS, the Company and Employee are entering into this Release as a condition to Employee's receipt of severance pay upon his or her termination of employment with the Company.

NOW, THEREFORE, the Company and Employee agree as follows:

1. **Termination Date.** Employee's employment with the Company shall terminate on **______________** (the "Termination Date"). Following termination of employment, Employee shall not represent to anyone that he or she is an employee of the Company and shall not say or do anything purporting to bind the Company. For purposes of this Agreement, Employee will be entitled to receive the severance payment and benefits set forth under Section 2 hereof only to the extent Employee's termination of employment constitutes a "separation from service," as defined in Treasury Regulation Section 1.409A-1(h), and, in the event that Employee's "separation from service" occurs on a date other than the date set forth above, the "Termination Date" shall mean the date of Employee's "separation from service."

2. **Severance Benefits.** Provided that Employee signs and delivers this Agreement to the Company on or before the twenty-first (21st) day after Employee's receipt of this Agreement and does not revoke his/her acceptance within seven (7) days after signing this Agreement, the Company will provide Employee with the following benefits and payments, subject to the terms and conditions set forth in this Release:

    a. Employee shall be entitled to receive a lump sum severance payment under the terms of Employee's employment agreement or an applicable Company severance policy (as in effect from time to time) in the amount of $______ (which is equal to ____ months of Employee's monthly base salary in effect as of the date set forth in Section 1), subject to withholding for payroll taxes and applicable deductions. The severance payment will be made on the regular Company payday for the first payroll period beginning after the Effective Date as defined in Section 4(d)(vi), and in no event later than March 15 following the calendar year in which the Termination Date occurs.

    In the event that the Company rehires Employee and the number of months between Employee's Termination Date and the date of his or her re-hire, if any, is less than the number of months of Employee's monthly base salary that was taken into account to calculate his or her lump sum severance payment, then the Employee shall repay to the Company an amount equal to the amount of his or her severance payment multiplied by a fraction, the numerator of which is the number of months on which the severance payment was based, minus the number of months (any partial month will be prorated) during which the Employee was unemployed by the Company, and the denominator of which is the number of months on which the severance payment was based (e.g. if an employee receives three months of severance pay and is re-hired by the Company two months after his or her Termination Date, he or she will be required to repay to the Company an amount equal to one month of severance pay.) In addition, upon re-hire the COBRA premium benefits set forth in Section 2(b) will cease when Employee becomes eligible as an employee for benefits under the Company's group health, vision and dental plans.

    In further consideration for the Employee's acceptance of this Agreement, the Company will provide outplacement services to the Employee rendered by Lee Hecht Harrison per the

Company's outplacement service program in effect as of the date of this Agreement. The Employee must enroll in the outplacement service program with Lee Hecht Harrison within sixty (60) days of the Employee’s Termination Date in order to be eligible to receive these outplacement service benefits. To the greatest extent applicable, such outplacement services shall be provided in a manner that is exempt from Section 409A of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations and Internal Revenue Service guidance thereunder (“Section 409A”) in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(A). In the event that the outplacement services constitute nonqualified deferred compensation subject to Section 409A of the Code, the outplacement services shall be provided in a manner that complies with Section 409A of the Code and the provisions of Section 19 hereof.

b. Effective as of the first day of the month immediately following the month in which the Termination Date occurs, Employee and Employee’s spouse/life partner and dependents who are covered under the Company’s employee welfare benefit plan which is a group health plan immediately prior to the Termination Date shall be eligible to elect to continue coverage under such plan, as required under and in accordance with Part VI (“COBRA”) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). If the appropriate COBRA election forms are completed, signed and returned by the applicable deadlines established by the Company, the Company shall pay on the Employee’s behalf the full cost of the COBRA coverage for group health plan and dental and vision benefits as employee had in effect immediately prior to the Termination Date under such plan until the earlier of (i) the end of ______ months from the Termination Date and (ii) the date Employee becomes eligible for coverage under a plan of another employer. If the group health, dental or vision benefit elected by Employee is replaced or becomes unavailable, the Company will pay for coverage under the replacement benefit or, if a benefit is not replaced, the most similar plan remaining in effect. If, upon the termination of the Company’s payment of such COBRA coverage, Employee continues to be entitled under federal law to receive COBRA coverage, then any such coverage shall be available to Employee, solely at Employee’s expense, at the full COBRA coverage rates then in effect. COBRA election forms will be mailed to Employee’s home address under separate cover. To the greatest extent applicable, such continued health coverage shall be provided in a manner that is exempt from Section 409A in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(B).

3. **Acknowledgements**.

a. Employee acknowledges and agrees that the payments and benefits set forth in Sections 2(a) and (b) above are payments and benefits to which Employee is not otherwise entitled, and Employee understands that if he or she does not sign this Release, or if he or she revokes acceptance of this Release, Employee shall not be entitled to these payments and benefits.

b. By signing below, Employee confirms and agrees that as of the Termination Date, Employee has been paid, or will be paid in his or her final regular paycheck (subject to withholding for taxes and applicable deductions), all accrued salary, unused accrued Paid Time Off, and other similar payroll related benefits and compensation due the Employee as of the Termination Date by virtue of his or her employment, in keeping with the Company’s policy and practice. Employee further acknowledges that no other compensation or wages are due and owing to Employee, and no further Paid Time Off or other benefits will accrue after the Termination Date.

c. Employee’s participation in all Company employee benefit plans as an active employee shall cease on the Termination Date, and Employee shall not be eligible to make contributions to or to receive additional Company contributions under the Health Net, Inc. 401(k) Associate Savings Plan, (the “401(k) Plan”) (other than any “supplemental Matching Contributions” made pursuant to the 401(k) Plan) or to make any deferrals pursuant to any deferred compensation plan of the Company after the Termination Date. All payments due Employee under employee benefit plans or arrangements in which Employee participates, including without limitation, the 401 (k) Plan and any deferred compensation plan of the Company, shall be paid to Employee pursuant to the terms and provisions of such plans. Notwithstanding the foregoing, if, immediately prior to the Termination Date, Employee participates in certain Company employee welfare benefit plans, Employee's participation in such plans may continue on the same terms and conditions, including the same co-payment terms, until the last day of the month in which the Termination Date occurs.

4. **Release.**

a. *General Release*. In return for the consideration set forth in Sections 2(a) and (b) above, Employee, on behalf of himself or herself, as well as Employee's heirs, beneficiaries, successors, representatives, trustees, administrators and assigns, freely and voluntarily hereby waives and releases the Company, and each of its past, present and future officers, directors, shareholders, employees, consultants, accountants, attorneys, agents, managers, insurers, sureties, parent and sister corporations, divisions, subsidiary corporations and entities, partners, joint venturers and affiliates (and each of their respective beneficiaries, successors, representatives and assigns) and all persons acting in concert with them (collectively, "Affiliates") from any and all claims, demands, damages, debts, liabilities, controversies, obligations, actions or causes of action of any nature whatsoever, whether based on tort, statute, contract, indemnity, rescission or any other theory of recovery, and whether for compensatory, punitive, equitable or other relief, whether known, unknown, suspected or unsuspected, against the Company and/or its Affiliates, including without limitation claims which may have arisen or may in the future arise in connection with any event that occurred on or before the date of Employee's execution of this Release.

These claims include but are not limited to claims arising under federal, state and local statutory or common law, including, but not limited to the Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq. ("ADEA"); Title VII of the Civil Rights Act of 1964, as amended by the Civil Rights Act of 1991, 42 U.S.C. § 2000 et seq.; Equal Pay Act, 29 U.S.C. § 206(d); the Civil Rights Act of 1866, 42 U.S.C. § 1981; the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; the False Claims Act, 31 U.S.C. § 3729 et seq.; the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq.; the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2101 et seq.; the California Fair Employment and Housing Act, Cal. Lab. Code § 12940 et seq.; the California Equal Pay Law, Cal. Lab. Code §§ 1197.5(a),1199.5; the Moore-Brown-Roberti Family Rights Act of 1991, Cal. Gov't Code §§12945.2, 19702.3; the California WARN Act, Cal. Lab. Code § 1400 et seq.; the California Labor Code; the California Constitution; (all as amended) claims arising out of any legal restrictions on the Company's right to terminate its employees; or claims arising under state and federal whistleblower statutes to the maximum extent permitted by law. Nothing herein shall be construed to impede the employee from communicating directly with, cooperating with or providing information to any government regulator.

b. *Unknown Claims*. Employee expressly waives any right or claim of right to assert hereafter that any claim, demand, obligation and/or cause of action has, through ignorance, oversight or error, been omitted from the terms of this Release. Employee makes this waiver with full knowledge of his or her rights and with specific intent to release both his or her known and unknown claims, and therefore specifically waives his or her rights under Section 1542 of the Civil Code of California or other similar provisions of any other applicable law (collectively, "Section 1542"), which reads as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."

Employee understands and acknowledges the significance and consequence of this Release and of such specific waiver of Section 1542, and expressly agrees that this Agreement shall be given full force and effect according to each and all of its express terms and provisions, including those relating to unknown and unsuspected claims, demands, obligations and causes of action herein above specified.

c. *Claims Not Released*. This Release does not waive rights or claims under federal or state law that Employee cannot waive by private agreement, including, but not limited to those he or she may have under Sections 2800 and 2802 of the California Labor Code, the Employee's right to file a claim for unemployment benefits, worker's compensation benefits, claims under the Fair Labor Standards Act, health insurance benefits under COBRA, or claims with regards to vested benefits under a retirement plan governed by ERISA.

d. *Review and Revocation*. In accordance with the Older Workers Benefit Protection Act, Employee acknowledges and agrees this Agreement includes a waiver and release of all claims that Employee have or may have under the ADEA. With respect to the release of claims under the ADEA, Employee acknowledges that:

(i) This Agreement is written in a manner calculated to be understood by Employee and Employee understands it.

(ii) The waiver and release of claims under the ADEA contained in this Agreement does not cover rights or claims that may arise after the date on which Employee signs this Agreement.

(iii) This Agreement provides for consideration in addition to anything of value to which Employee is already entitled.

(iv) Employee is hereby advised to consult an attorney before signing this Agreement.

(v) Employee has been granted twenty-one (21) days after receiving this Agreement to decide whether or not to sign this Agreement. If Employee signs this Agreement prior to the expiration of the twenty-one (21) day period, Employee does so voluntarily and after having had the opportunity to consult with an attorney, and Employee hereby waives the remainder of the twenty-one (21) day period.

(vi) Employee has the right to revoke this Agreement within seven (7) days of signing this Agreement, and this Agreement shall not be enforceable or effective until the eighth (8th) day after he or she signs this Agreement (the "Effective Date").

(vii) In the event this Agreement is revoked, this Agreement will be null and void in its entirety, and Employee will not be entitled to the payments and benefits provided in Section 2 of this Agreement. If Employee wishes to revoke this Agreement, Employee must deliver written notice stating his or her intent to revoke this Agreement to the Company's _______________, on or before 5:00 p.m. on the seventh (7th) day after the date on which Employee signed this Agreement.

5. **No Future Actions.** To the extent permitted by law, Employee agrees that Employee shall not encourage, cooperate in, or initiate any suit or action of any kind, or voluntarily participate in same, individually or as a representative, witness or member of a class, under contract, law or regulation, federal, state or local, pertaining to any matter related to his or her employment with the Company. Employee represents that he or she has not, to date, initiated (or caused to be initiated) any such suit or action.

Exhibit 10.9

Employee agrees that if he or she, or anyone purporting to act on his or her behalf or under any assignment of claims from Employee, hereafter commences any suit arising out of, based upon, or relating to any of the claims released by the Agreement or in any manner asserts against the Company and/or its Affiliates, any of the claims released hereunder, then, to the maximum extent permitted by law, Employee will pay to the Company and/or its Affiliates, as applicable, in addition to any other damages caused to them thereby, all attorneys' fees incurred by the Company and/or its Affiliates, as applicable, in defending or otherwise responding to said suit or claim.

The foregoing shall not apply if Employee is required to participate by legal process or other requirement of applicable law, provided that Employee gives the Company notice if legal process is served on the Employee; or to any challenge by Employee to the validity of any release herein of ADEA claims or to any to suit or action brought by Employee to assert such a challenge.

Additionally, nothing in this Release precludes Employee from participating in any investigation or proceeding before any federal or state agency, or governmental body, including, but not limited to, the Equal Employment Opportunity Commission, the Securities and Exchange Commission, and/or the Department of Justice. However, while Employee may file a charge, provide information, or participate in any investigation or proceeding, by signing this Release, Employee, to the maximum extent permitted by law, waives any right to bring a lawsuit against the Company, and waives any right to any individual monetary recovery in any such proceeding or lawsuit or in any proceeding brought based on any communication by Employee to any federal, state or local government agency or department.

6. **Cooperation with the Company.** In addition, Employee shall, without further compensation, cooperate with and assist the Company in the investigation of, preparation for or defense of any actual or threatened third party claim, investigation or proceeding involving the Company or its predecessors or affiliates and arising from or relating to, in whole or in part, Employee's employment with the Company or its predecessors or affiliates for which the Company requests Employee's assistance, which cooperation and assistance shall include, but not be limited to, providing truthful testimony and assisting in information and document gathering efforts. In connection herewith, it is agreed that the Company will use its reasonable best efforts to assure that any request for such cooperation will not unduly interfere with Employee's other material business and personal obligations and commitments.

7. **Return of Company Property.** Employee agrees he or she shall return to the Company immediately upon termination of employment any building key(s), security pass or other access or identification cards and any and all Company property in his or her possession, including but not limited to any books, documents, credit cards, computer equipment, software, mobile phones or data files. Employee agrees to submit all expense accounts and to pay promptly the outstanding balance on each corporate credit card that the Company previously issued to Employee. Compliance with this Section is a condition precedent to the Company's obligation to provide the payments and benefits set forth in Section 2.

8. **Confidential Information.** To the maximum extent permitted by law, Employee shall not, without the Company's written consent by an authorized representative, at any time prior or subsequent to the execution of this Release, disclose, use, remove or copy any Confidential Information, trade secret or proprietary information he or she acquired during the course of his or her employment by the Company. "Confidential Information," for purposes of this Agreement, includes any information not previously published or generally in the public domain. Confidential Information, trade secrets and proprietary information includes without limitation, any technical, actuarial, economic, financial, procurement, provider, enrollee, customer, underwriting, contractual, managerial, marketing or other information of any type regarding the business in which the Company is engaged, but not including any previously published information or other information generally in the public domain. Employee also agrees that he or she shall not without the Company's written consent by an authorized representative, directly or indirectly use the Company's trade secret information, including but not limited to customer lists, to solicit business of any customers of the Company (other than on behalf of the Company). Employee acknowledges and agrees that any "Invention," including without limitation, any developments or discoveries by Employee during

the course of his or her employment with the Company through the date of execution of this Release resulting in patents, lists of customers, trade secrets, specialized know-how or other intellectual property useful in the then-current business of the Company and any original works of authority are the property of the Company and shall be used for the sole benefit of the Company. If not previously assigned to the Company, Employee hereby assigns ownership of any and all Inventions to the Company, provided, however, that the provisions of this Agreement requiring assignment of Inventions to the Company do not apply to any invention which qualifies fully under the provisions of California Labor Code section 2870, which provides as follows:

"(a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either:

(1) Relate at the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or

(2) Result from any work performed by the employee for the employer.

(b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable."

This provision shall supplement, but not limit or supersede any other agreement between Employee and the Company concerning any Confidential Information or other intellectual property.

9. **Non-Solicitation.** In addition to any other part or term of this Release, Employee agrees that he or she shall not, for a period of one (1) year from the date of this Agreement, regardless of the reason for Employee's termination of employment, without the Company's written consent by an authorized representative, on his or her own behalf or on behalf of any other person, either directly or indirectly, solicit, recruit, encourage or induce any employee, agent, provider, vendor or independent contractor with whom Employee became acquainted during the course of employment to terminate such a person's or entity's relationship with the Company or to associate with a competitor of the Company. The prohibitions of this paragraph are not intended to deny employment opportunities within the Employee's field of employment but are limited only to those prohibitions necessary to protect the Company from unfair competition.

10. **No Disparagement.** Employee further agrees and acknowledges that in exchange for the consideration identified in Sections 2 (a) and (b) above, he or she shall not make any disparaging comments and/or statements to anyone either orally or in writing about the Company and/or its employees.

11. **No Admission.** Nothing contained herein shall be construed as an admission of any wrongful act, including, but not limited to, violation of any contract, express or implied, or any federal, state or local employment laws or regulations, and nothing contained herein shall be used for any purpose except in proceedings related to the enforcement of this Release.

12. **Arbitration of Disputes.** If there is any dispute between the Company and the Employee over the terms or obligations under this Release, that dispute shall be resolved by binding arbitration before a single neutral arbitrator who shall be a retired judge. The arbitration shall proceed in accordance with the then-current Employment Rules of the American Arbitration Association. The judgment of the arbitrator shall be final, binding and nonappealable, and may be entered in any state or federal court having jurisdiction thereafter. The arbitrator shall be bound to apply and follow the applicable state or federal laws in reaching a decision in this matter. Any disagreement regarding whether a dispute is required to be arbitrated pursuant to this Release shall be decided by the arbitrator. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall govern the interpretation and enforcement of this paragraph.

Notwithstanding the above paragraph, the arbitration procedure shall not prohibit Employee or the Company from seeking injunctive relief, including without limitation, temporary or preliminary injunctive relief, through any court of competent jurisdiction if such relief is not available or is not available in a timely manner, through arbitration.

13. **Confidentiality.** Employee represents and agrees that he or she will keep the terms, amounts and facts of this Release completely confidential, and that he or she will not hereafter disclose any information concerning this Release to anyone except his or her immediate family, attorneys or accountants or taxing authorities, except as may be required by law. Employee agrees that if Employee discloses this Release to anyone in his or her immediate family, his or her attorney(s), or his or her accountant(s), Employee will ensure that the individual to whom Employee discloses the Agreement understands that he or she is also subject to this confidentiality provision. Employee agrees that he or she is liable for any breach of this provision by his or her immediate family, attorney(s) or accountant(s), in the same manner and with the same consequences as if the Employee himself/herself had breached this provision. This provision shall not apply to any information that becomes generally known as a result of disclosure by the Company.

14. **Severability.** Should any part, term or provision of this Release be declared and/or be determined by any court or arbitrator to be illegal or invalid, the validity of the remaining parts, terms or provisions shall not be affected thereby, and said illegal or invalid part, term or provision shall be deemed not to be a part of this Release.

15. **Entire Agreement/No Oral Modification.** This Release contains the entire agreement between the parties hereto, and fully supersedes any and all prior agreements or understandings between the parties hereto pertaining to the subject matter hereof. There may be no modification of the terms of this Release except in writing signed by the parties hereto.

16. **Opportunity to Consult with Counsel.** Employee acknowledges that he or she has had an opportunity to consult with and be represented by counsel of Employee’s choosing in the review of this Release, that he or she has been advised by the Company to do so, that the Employee is fully aware of the contents of the Release and of its legal effect, that the preceding paragraphs recite the sole consideration for this Release, and that Employee enters into this Release freely, without duress or coercion, and based on the Employee’s own judgment and wishes and not in reliance upon any representation or promise made by the Company, other than those contained herein.

17. **Choice of Law.** Except as otherwise stated herein, this Release shall in all respects be interpreted, enforced and governed under the laws of the State of California. The language of all parts of this Release shall in all cases be construed as a whole, according to its fair meaning, and not strictly for or against any of the parties.

18. **Reformation.** In the event any part, term or provision herein is not enforceable including because its geographic scope, length or subject matter is determined to be excessive, then such part, term or provision shall be reformed to the minimum extent necessary to make such part, term or provision enforceable.

19. **Outplacement and Section 409A.** To the extent that the outplacement services provided under Section 2(a) and/or the continued health benefits payable under Section 2(b) constitute non-exempt “nonqualified deferred compensation” (within the meaning of Section 409A) that is subject to Section 409A, such benefits shall be provided in a manner that complies with the requirements of Treasury Regulation Section 1.409A-3(i)(1)(iv), including, without limitation, the following conditions: (i) the benefits payable in Employee’s taxable year may not affect such benefits that Employee is eligible to receive in another taxable year of Employee; (ii) the reimbursement of expenses or provision of in-kind benefits shall be made on or before the last day of Employee’s taxable year following the taxable year in which the expense or obligation is incurred; and (iii) such benefits shall not be subject to liquidation or exchange for another benefit.

20. **Headings.** The headings of the Sections of this Agreement are provided for convenience only. They do not alter or limit, in any way, the text of any Section of this Agreement.

21. **Acceptance and Expiration.** Employee has up to twenty-one (21) calendar days from the date he or she receives this document to consider and accept the terms of this Release, but may accept it at any time within those twenty-one (21) calendar days. Employee agrees that changes to the terms or form of this Release, whether material or immaterial do not restart the running of the twenty-one (21) day period. After twenty-one (21) calendar days have passed, this offer will expire.

Exhibit 10.9

EMPLOYEE ACKNOWLEDGES BY SIGNING BELOW that (i) Employee has not relied upon any representations, written or oral, not set forth in this Release; (ii) at the time Employee was given this Release, Employee was informed in writing by the Company that: (a) Employee had at least twenty-one (21) calendar days in which to consider whether Employee would sign the Release; (b) Employee was advised to consult with an attorney before signing the Release; and (c) Employee had seven (7) calendar days to revoke this Agreement after signing it; (iii) Employee had an opportunity to consult with an attorney and either had such consultations or has freely decided to sign this Release without consulting an attorney; and (iv) Employee executes this Release knowingly and voluntarily.

IN WITNESS WHEREOF, the parties hereto have executed this Release as of the dates set forth below.

Employee Health Net, Inc.

By: By: ______________________________
Name: Name:
Title:

Dated: Dated: _____________________________

NOTE: Please return your signed waiver and release to:
Organization Effectiveness Unit
Attention: (Name, Title)
(Address, City, State, Zip Code)

Exhibit 10.10

AMENDED AND RESTATED EMPLOYMENT AGREEMENT

This AMENDED AND RESTATED EMPLOYMENT AGREEMENT (this "Agreement") is made and entered into as of February 24, 2015, by and between Health Net, Inc., a Delaware corporation (the "Company"), with its principal place of business located at 21650 Oxnard Street, Woodland Hills, California 91367, and Steve Tough ("Executive"). This Agreement amends and restates the Prior Agreement (as defined below) in its entirety.

RECITALS

WHEREAS, the Company and Executive previously entered into that certain Amended and Restated Employment Agreement, dated November 6, 2012 (the "Prior Agreement"); and

WHEREAS, the Company and Executive desire to amend and restate the Prior Agreement on the terms and conditions set forth herein, and to supersede the Prior Agreement in all respects effective as of October 9, 2014 (the "Effective Date").

NOW, THEREFORE, in consideration of the following covenants, conditions and promises contained herein, and other good and valuable consideration, the Company and Executive hereby agree as follows:

1. Duties and Salary.

A. Duties. Executive's title is President, Government Programs, but may be changed at the discretion of the Company to a title that reflects a similarly situated senior executive position. Executive shall report directly to Jim Woys, Executive Vice President, Chief Financial and Operating Officer and Interim Treasurer of the Company, but Executive's reporting relationship may be changed from time to time at the discretion of the Company. Executive's duties and responsibilities are to provide strategic direction and leadership to, and promote revenue growth and profitability of, the Company's government business under the Government Programs Division, including Health Net Federal Services (HNFS), MHN Government Services, Government Administrative Programs, Medicaid Business Units and the Dual Eligible Program. In connection with the foregoing responsibilities, Executive's duties shall include, but shall not be limited to, the establishment and execution of strategic direction in matters of program management, financial performance, sales, marketing, business development, operations, compliance and organization effectiveness. However, the Company reserves the right to assign Executive other duties as needed and to change Executive's duties from time to time on reasonable notice, based on Executive's skills and the needs of the Company. In the event that Executive performs any such additional duties, Executive shall not be entitled to an increase in compensation beyond that specified in this Agreement.

B. Salary. As of February 21, 2015, Executive will be paid a base salary at the annual rate of $577,029, which salary will be paid on a pro-rated bi-weekly basis, less applicable withholdings ("Base Salary"), covering all hours worked. Generally, Executive's Base Salary will be reviewed annually, but the Company reserves the right to change Executive's compensation from time-to-time. Pursuant to the charter of the Compensation Committee of the Company's Board of Directors (the "Committee"), any adjustment to Executive's compensation must be made with the approval of the Committee and, in the event that Executive constitutes one of the top two (2) highest paid executive officers of the Company, with the ratification of the Company's Board of Directors.

A. Disclosure of Personal Compensation Information. As an "executive officer" of the Company (as such term is defined in the rules and regulations of the Securities and Exchange Commission ("SEC")), information regarding Executive's employment arrangements with the Company, including, among other things, the terms of this Agreement and any stock option agreement, restricted stock agreement, restricted stock unit agreement, performance share agreement and/or severance agreement Executive enters into with the Company from time to time (collectively, "Personal Compensation Information"), may be disclosed in filings with the SEC, the New York Stock Exchange ("NYSE") and/or other regulatory organizations upon the occurrence of certain triggering events. Such triggering events include, but are not limited to, the execution of this Agreement and any amendments thereto, changes in Executive's Base Salary, any annual incentive payment (whether in the form of cash or equity) awarded to Executive (in the past or after the date hereof), and the establishment of performance goals under the Company's incentive plans. Executive's execution of this Agreement will serve as Executive's acknowledgement that Executive's Personal Compensation Information may be publicly disclosed from time to time in filings with the SEC, NYSE or otherwise as necessary.

2. Adjustments and Changes in Employment Status. Executive understands that the Company reserves the right to make personnel decisions regarding Executive's employment, including, but not limited to, decisions regarding any promotion, salary adjustment, transfer or disciplinary action, up to and including Termination (as defined below), consistent with the needs of the business of the Company.

For purposes of this Agreement, the capitalized terms "Termination" and "Terminate," shall mean Executive's Separation from Service (as defined below) from the Company. A "Separation from Service" with respect to Executive shall mean a "separation from service," as defined in Treasury Regulation Section 1.409A-1(h) or any regulation that supersedes such regulation.

3. Protection of Proprietary and Confidential Information. Executive agrees that Executive's employment creates a relationship of confidence and trust with the Company with respect to Proprietary and Confidential Information (as defined below) of the Company learned by Executive during Executive's employment.

A. Executive agrees not to directly or indirectly use or disclose any of the Proprietary and Confidential Information of the Company or any of its affiliates at any time except in connection with the services Executive provides to such entities. "Proprietary and Confidential Information" shall mean trade secrets, confidential knowledge, data or any other proprietary or confidential information of the Company or any of its affiliates, or of any customers, members, employees or directors of any of such entities, but shall not include any information that (i) was publicly known and made generally available in the public domain prior to the time of disclosure to Executive by the Company or (ii) becomes publicly known and made generally available after disclosure to Executive by the Company other than as a result of a disclosure by Executive in violation of this Agreement. By way of illustration but not limitation, “Proprietary and Confidential Information” includes: (i) trade secrets, documents, memoranda, reports, files, correspondence, lists and other written and graphic records affecting or relating to any such entity’s business; (ii) confidential marketing information including without limitation marketing strategies, customer and client names and requirements, services, prices, margins and costs; (iii) confidential financial information; (iv) personnel information (including without limitation employee compensation); and (v) other confidential business information.

B. Executive further agrees that at all times during Executive’s employment and thereafter, Executive will keep in confidence and trust all Proprietary and Confidential Information, and that Executive will not use or disclose any Proprietary and Confidential Information or anything related to such information without the written consent of the Company, except as may be necessary in the ordinary course of performing Executive’s duties to the Company.

C. All Company property, including, but not limited to, Proprietary and Confidential Information, documents, data, records, apparatus, equipment and other physical property, whether or not pertaining to Proprietary and Confidential Information, provided to Executive by the Company or any of its affiliates or produced by Executive or others in connection with Executive’s providing services to the Company or any of its affiliates shall be and remain the sole property of the Company or its affiliates (as the case may be) and shall be returned promptly to such appropriate entity as and when requested by such entity. Executive shall return and deliver all such property upon termination of Executive’s employment, and Executive may not take any such property or any reproduction of such property upon such termination.

D. Executive recognizes that the Company and its affiliates have received and in the future will receive information from third parties which is private, proprietary or confidential information subject to a duty on such entity’s part to maintain the confidentiality of such information and to use it only for certain limited purposes. Executive agrees that during Executive’s employment, and thereafter, Executive owes such entities and such third parties a duty to hold all such private, proprietary or confidential information received from third parties in the strictest confidence and not to disclose it, except as necessary in carrying out Executive’s work for such entities consistent with such entities’ agreements with such third parties, and not to use it for the benefit of anyone other than for such entities or such third parties consistent with such entities’ agreements with such third parties.

E. Executive’s obligations under this Section 3 shall continue after the Termination of Executive’s employment and any breach of this Section 3 shall be a material breach of this Agreement.

4. Physical Exam. Executive shall be required, on an annual basis, to undergo a physical examination and to send evidence that Executive has undergone such exam (but in no case the results of such exam) to the Senior Vice President of Organization Effectiveness. The Company shall reimburse Executive for any out-of-pocket expenses relating to the physical examination that are not otherwise covered by Executive’s health insurance plan.

5. Representations and Warranties of Executive.

A. No Violation; No Conflicts. Executive represents and warrants to the Company that the entering into of this Agreement and Executive's performance of Executive's duties hereunder, will not violate any agreements with, or trade secrets of, any other person or entity. Executive further represents and warrants that Executive does not have any relationship or commitment to any other person or entity that might be in conflict with Executive's obligations to the Company under this Agreement, including but not limited to outside employment, sales broker relationships, investments or business activities. Executive understands and agrees that while employed by the Company Executive is expected to refrain from engaging in any outside activities that might be in conflict with the business interests of the Company. In addition, Executive represents and warrants to the Company that Executive has not shared with or disclosed to, and will not share with or disclose to, the Company any proprietary or confidential information of Executive's previous employers or any other third party.

B. Legal Proceedings. Executive represents and warrants to the Company that Executive has not been arrested, indicted, convicted or otherwise involved in any criminal or civil action or legal matter that could affect Executive's ability to perform Executive's duties hereunder or that may have a negative impact on the Company, its reputation or its operations. Executive agrees, to the extent permitted by applicable law, to notify the Company's Senior Vice President of Organization Effectiveness immediately in the event that Executive becomes party to any criminal or civil action or other legal matter in the future that could have an affect on the foregoing representation.

6. Executive Benefits.

A. Employee Benefit Programs. Executive shall be eligible to participate in the Company's various employee benefit programs and plans in place from time to time in accordance with their terms, as long as Executive remains employed by the Company and Executive meets the applicable participation requirements. These benefit programs and plans currently include paid time off ("PTO"), holidays, group medical, dental, vision, term life, and short and long term disability insurance and participation in the Company's 401(k) plan, tuition reimbursement plan and deferred compensation plan. The Company or its subsidiaries or affiliates may modify, terminate or amend any benefit or plan in its discretion, retroactively or prospectively, subject only to applicable law.

B. Required Insurance. Executive will be covered by workers' compensation insurance and state disability insurance, as required by state law.

C. Fringe Benefits. Executive will be entitled to such fringe benefits and perquisites as are provided by the Company from time to time, in accordance with the Company's policies, practices and procedures, and shall receive such additional fringe benefits and perquisites as the Company may, in its discretion, from time-to-time provide. Without limiting the generality of the foregoing, Executive will be entitled to be reimbursed up to the amount of $5,000 per year for documented costs incurred for personal financial counseling services provided to Executive, including tax preparation, as long as Executive remains employed by the Company.

A. Incentive Bonus. Executive will be eligible to participate in the Health Net, Inc. Management Incentive Plan, or such other Company bonus plan that may be in effect from time to time, in accordance with the terms of such plan, which provides Executive with a target bonus for each plan year equal to 80% of Executive's Base Salary as additional compensation according to the terms of such plan. The actual bonus payment will range from 0% to 200% of target depending upon the actual results achieved. It is understood that the Committee and the Company will award bonus amounts, if any, as it deems appropriate consistent with the MIP or such other bonus plan that may be in effect from time to time.

B. Expenses. Subject to and in accordance with the Company's written policies for business and travel expenses, Executive will receive reimbursement for all business travel and other out-of-pocket expenses reasonably incurred by Executive in the performance of Executive's duties pursuant to this Agreement.

C. Insurance Coverage. Irrespective of whether Executive remains employed by the Company, the Company will provide Executive and Executive's dependents with health (medical, dental and vision) insurance coverage, at no charge to Executive or Executive's dependents, for the remainder of Executive's life, which coverage shall be no less beneficial to Executive and Executive's dependents than the coverage provided Executive by Foundation Health Corporation ("FHC") immediately prior to the 1997 merger of FHC and Health Systems International.

7. Equity Grants; Stock Ownership Requirement.

A. Future Equity Grants. Any future equity grants made to Executive will be granted under one of the Company's Long-Term Incentive Plans, and will be subject to the terms of such plan and of the agreement executed in connection with such grant. Any future equity grants to Executive will be made at the discretion of the Committee.

B. Company Stock Ownership Requirement. In accordance with the Executive Officer Stock Ownership Policy adopted by the Board of Directors of the Company, as may be amended from time to time (the "Executive Stock Ownership Policy"), Executive is currently required to own "Qualifying Shareholdings" (as defined in the Executive Stock Ownership Policy) having a value of one time (1x) Executive's Base Salary in effect from time to time pursuant to this Agreement (the "Stock Ownership Requirement"). The number of Qualifying Shareholdings Executive is required to own will be calculated based on the average NYSE closing price per share of the Company's Common Stock (as adjusted for stock splits and similar changes to the Common Stock) for the most recently completed fiscal year of the Company.

Using Executive's Base Salary as of February 21, 2015, which was $577,029, and a stock price of $41.04, which was the average closing price per share of the Company's Common Stock for the fiscal year ended December 31, 2014, Executive's Stock Ownership Requirement as of February 21, 2015 was 14,061 shares ("Target Amount"). The Target Amount is subject to change from time to time based on (1) changes in the average closing price per share of the Company's Common Stock on an annual basis, (2) any changes in Executive's Base Salary made pursuant to and in accordance with Section 1(B) of this Agreement, and (3) any changes under the terms of the Executive Stock Ownership Policy.

Exhibit 10.10

Under the Executive Stock Ownership Policy as currently in effect, to the extent that Executive has not achieved the Stock Ownership Requirement, Executive must hold 75% of all "net settled shares" received from the vesting, delivery or exercise of equity awards granted under the Company's equity award (including long-term incentive) plans, as such term is defined in the Executive Stock Ownership Policy.

The Committee expects that Executive will make reasonable progress toward Executive's Stock Ownership Requirement. Executive will be notified on an annual basis of any changes in Executive's Target Amount.

8. Term of Employment. Executive's employment with the Company is at the mutual consent of Executive and the Company. Nothing in this Agreement is intended to guarantee Executive's continuing employment with the Company or employment for any specific length of time. Accordingly, either Executive or the Company may terminate the employment relationship at any time and for any reason whatsoever (or for no reason), subject to certain notice requirements, to the extent applicable, as set forth herein. Upon Termination of Executive's employment for any reason, in addition to any other payments that may be payable to Executive hereunder, Executive (or Executive's beneficiaries or estate) shall be paid (in each case to the extent not theretofore paid) within thirty (30) days following Executive's date of Termination (or such shorter period that may be required by applicable law): (a) Executive's annual Base Salary through such Termination date, (b) accrued but unused PTO, (c) reimbursable expenses incurred by Executive prior to the Termination date and (d) amounts to which Executive may be entitled through such Termination date under any other compensatory plan, arrangement or program payment in accordance with the terms thereunder. This Agreement constitutes a final and fully binding integrated agreement with respect to the at-will nature of the employment relationship.

9. Termination of Employment/Severance Pay.

A. Termination Without Cause Not Following Change in Control. If Executive's employment is Terminated by the Company without "Cause" (as defined in Section 9(D) below) at any time that is not within two (2) years after a "Change in Control" (as defined below) of Health Net, Inc., Executive will be entitled to receive, within thirty (30) days following the Termination of Executive's employment, provided that Executive signs and delivers prior to the expiration of such (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, a lump sum cash payment equal to twelve (12) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination.

For purposes of this Agreement, "Change in Control" is defined as any of the following which occurs subsequent to the Effective Date:

(i) Any person (as such term is defined under Section 13(d)(3) of the Securities Exchange Act of 1934, as amended (the "Exchange Act")), corporation or other entity (other than Health Net, Inc. or any of its subsidiaries, or any employee benefit plan sponsored by Health Net, Inc. or any of its subsidiaries) is or becomes the beneficial owner (as such term is defined in Rule

13d-3 under the Exchange Act) of securities of Health Net, Inc. representing twenty percent (20%) or more of the combined voting power of the outstanding securities of Health Net, Inc. which ordinarily (and apart from rights accruing under special circumstances) have the right to vote in the election of directors (calculated as provided in paragraph (d) of such Rule 13d-3 in the case of rights to acquire Health Net, Inc.'s securities) (the "Securities");

(ii) As a result of a tender offer, merger, sale of assets or other major transaction, the persons who are directors of Health Net, Inc. immediately prior to such transaction cease to constitute a majority of the Board of Directors of Health Net, Inc. (or any successor corporations) immediately after such transaction;

(iii) Health Net, Inc. is merged or consolidated with any other person, firm, corporation or other entity and, as a result, the shareholders of Health Net, Inc., as determined immediately before such transaction, own less than eighty percent (80%) of the outstanding Securities of the surviving or resulting entity immediately after such transaction;

(iv) A tender offer or exchange offer is made and consummated for the ownership of twenty percent (20%) or more of the outstanding Securities of Health Net, Inc.;

(v) Health Net, Inc. transfers substantially all of its assets to another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc.; or

(vi) Health Net, Inc. enters into a management agreement with another person, firm, corporation or other entity that is not a wholly-owned subsidiary of Health Net, Inc. and such management agreement extends hiring and firing authority over Executive to an individual or organization other than Health Net, Inc.

B. Termination Without Cause or For Good Reason Following Change in Control. If at any time within two (2) years after a Change in Control of Health Net, Inc. Executive's employment is Terminated by the Company without Cause or Executive Terminates Executive's employment for "Good Reason" (as defined below) (by giving the Company at least fourteen (14) days prior written notice of the effective date of Termination), then Executive will be entitled to receive, within thirty (30) days following the Termination of Executive's employment, provided that Executive signs and delivers prior to the expiration of such thirty (30) day period, and does not revoke or attempt to revoke, a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, a lump sum payment equal to twenty-four (24) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, provided, that in the event the Company requests, in writing, prior to such voluntary Termination by Executive for Good Reason that Executive continue in the employ of the Company for a period of time up to 90 days following such Change in Control, then Executive shall forfeit such severance allowance if Executive voluntarily leaves the employ of the Company prior to the expiration of such period of time.

For purposes of this Agreement, the term "Good Reason" means any of the following which occurs, without Executive's consent, subsequent to the effective date of a Change in Control as defined above:

(i) A substantial reduction in the scope of Executive's authority, duties or responsibilities with the Company, except in connection with the Termination of Executive's employment for Disability (as defined below), normal retirement or Cause or by Executive voluntarily other than for Good Reason;

(ii) A material reduction by the Company in Executive's base compensation (i.e., Executive's Base Salary and/or target annual bonus) as in effect immediately prior to any such reduction

(iii) A relocation of Executive to a work location more than fifty (50) miles from Executive's work location immediately prior to such proposed relocation; provided that such proposed relocation results in a materially greater commute for Executive based on Executive's residence immediately prior to such relocation; or

(iv) The failure of the Company to obtain an assumption agreement from any successor contemplated under Section 12 of this Agreement.

<u>provided</u>, <u>however</u>, that (a) Executive provides written notice to the Company of the existence of the condition described above within ninety (90) days of the initial existence of the condition, (b) the Company fails to cure such condition within thirty (30) days after receipt of such written notice, and (c) the date of Executive's Termination occurs no later than seventy-five (75) days after the initial occurrence of the event constituting Good Reason, in accordance with Treasury Regulation Section 1.409A-1(n)(2)(ii)

C. <u>Voluntary Termination</u>. Notwithstanding anything to the contrary in this Agreement, whether express or implied, Executive may at any time Terminate Executive's employment for any reason by giving the Company fourteen (14) days prior written notice of the effective date of Termination. In the event that Executive voluntarily Terminates employment with the Company (except for Good Reason within two (2) years after a Change in Control of Health Net, Inc., as described in Section 9 (B) hereof), then Executive shall not be eligible to receive any payments or continuation of benefits set forth in this Section 9.

D. <u>Termination by the Company for Cause.</u> The Company may Terminate Executive's employment for "Cause" at any time with or without advance notice. In the event of such Termination, Executive will not be eligible to receive any of the payments set forth in Section 9(A) or 9(B) above. For purposes of this Agreement, a Termination for "Cause" is defined as: (i) an act of dishonesty causing harm to the Company or any of its affiliates, (ii) the material breach of either the Company's Code of Business Conduct and Ethics (the "Code of Conduct") or any policy or procedure developed and published by the Company regarding compliance or ethics related to the Code of Conduct, (iii) habitual drunkenness or narcotic drug addiction, (iv) conviction of, or entry by Executive of a guilty or no contest plea to, the commission of a felony or a misdemeanor involving moral turpitude, (v) willful refusal to perform or gross neglect of the duties assigned to Executive, (vi) the willful breach of any law that, directly or indirectly, affects the Company or any of its affiliates, (vii) a material breach by Executive following a Change in Control of those duties and responsibilities of Executive that do not differ in any material respect from Executive's duties and responsibilities during the 90-day period immediately prior to such Change in Control (other than as a result of incapacity due to physical or mental illness) which is demonstrably willful and deliberate on Executive's part, which is committed in bad faith or without reasonable belief that such breach is in the best interests of the Company or any of its affiliates and which is not remedied in a reasonable period of time after receipt of written notice from the Company specifying such breach, or (viii) breach of Executive's obligations hereunder (or under any Company policy) to protect the proprietary and confidential information of the Company or any of its affiliates.

E. Termination Due to Death or Disability. In the event that Executive's employment is Terminated at any time due to Executive's death or "Disability" (as defined below), Executive (or Executive's beneficiaries or estate) shall be entitled to receive, provided Executive (or Executive's beneficiaries or estate, as applicable) signs a Waiver and Release of Claims substantially in the form attached hereto as Exhibit A, as may be revised by the Company from time to time, which is incorporated into this Agreement by reference, (i) continuation of Executive's benefits for a period of twelve (12) months from the date of Termination, and (ii) a lump sum payment equal to twelve (12) months of Executive's Base Salary in effect immediately prior to the date of Executive's Termination, to be paid within thirty (30) days following Executive's Termination of employment. For purposes of this Agreement, a Termination for "Disability" shall mean a Termination of Executive's employment due to Executive's absence from Executive's duties with the Company on a full-time basis for at least 180 consecutive days as a result of Executive's incapacity due to physical or mental illness which is determined to be total and permanent by a physician selected by the Company or its insurers.

10. Withholding. All payments required to be made by the Company hereunder to Executive or Executive's estate or beneficiaries shall be subject to the withholding of such amounts relating to taxes as the Company may reasonably determine should be withheld pursuant to any applicable law or regulation.

11. Restrictive Covenants.

A. Non-Competition. Executive hereby agrees that, during (i) the six (6)-month period following a Termination of Executive's employment with the Company that entitles Executive to receive severance benefits under this Agreement or a written agreement with or policy of the Company or (ii) the twelve (12)-month period following a Termination of Executive's employment with the Company that does not entitle Executive to receive such severance benefits (the period referred to in either clause (i) or (ii), the "Restricted Period"), Executive shall not undertake any employment or activity (including, but not limited to, consulting services) with a Competitor (as defined below) in any geographic area in which the Company or any of its affiliates operate (the "Market Area"), where the loyal and complete fulfillment of the duties of the competitive employment or activity would call upon Executive to reveal, to make judgments on or otherwise use or disclose any confidential business information or trade secrets of the business of the Company or any of its affiliates to which Executive had access during Executive's employment with the Company. For purposes of this Section, "Competitor" shall refer to any health maintenance organization or insurance company that provides managed health care or related services similar to those provided by the Company or any of its affiliates.

B. Non-Solicitation. In addition, Executive agrees that, during the applicable Restricted Period following Termination of Executive's employment with the Company, Executive shall not, directly or indirectly, (i) solicit, interfere with, hire, offer to hire or induce any person, who is or was an employee of the Company or any of its affiliates at the time of such solicitation, interference, hiring, offering to hire or inducement, to discontinue his/her relationship with the Company or any of its affiliates or to accept employment by, or enter into a business relationship with, Executive or any other entity or person or (ii) solicit, interfere with or otherwise contact any customer or client of the Company or any of its affiliates.

C. Modification of Restrictions. It is hereby further agreed that if any court of competent jurisdiction shall determine that the restrictions imposed in this Section 11 are unreasonable (including, but not limited to, the definition of Market Area or Competitor or the time period during which this provision is applicable), the parties hereto hereby agree to any restrictions that such court would find to be reasonable under the circumstances.

D. Injunction Rights. Executive also acknowledges that the services to be rendered by Executive to the Company are of a special and unique character, which gives this Agreement a peculiar value to the Company or any of its affiliates, the loss of which may not be reasonably or adequately compensated for by damages in an action at law, and that a material breach or threatened breach by Executive of any of the provisions contained in this Section 11 will cause the Company or any of its affiliates irreparable injury. Executive therefore agrees that the Company may be entitled, in addition to the remedies set forth above in this Section 11 and any other right or remedy, to a temporary, preliminary and permanent injunction, without the necessity of proving the inadequacy of monetary damages or the posting of any bond or security, enjoining or restraining Executive from any such violation or threatened violations.

12. Successors; Binding Agreement.

A. Survival Following Merger, Consolidation or Asset Transfer. This Agreement shall not be terminated by any merger or consolidation of the Company whereby the Company is or is not the surviving or resulting corporation or as a result of any transfer of all or substantially all of the assets of the Company. In the event of any such merger, consolidation or transfer of assets, the provisions of this Agreement shall be binding upon the surviving or resulting corporation or the person or entity to which such assets are transferred.

B. Survivor's Assumption of Agreement. The Company agrees that concurrently with any merger, consolidation or transfer of assets referred to in this Section 12, it will cause any successor or transferee to unconditionally assume, by written instrument delivered to Executive (or Executive's beneficiary or estate), all of the obligations of the Company hereunder. Failure of the Company to obtain such assumption prior to the effectiveness of any such merger, consolidation or transfer of assets shall entitle Executive to compensation and other benefits from the Company in the same amount and on the same terms as Executive would be entitled hereunder if Executive's employment were Terminated without Cause. For purposes of implementing the foregoing, the date on which any such merger, consolidation or transfer becomes effective shall be deemed the date of Termination.

C. Enforceability. This Agreement shall inure to the benefit of and be enforceable by Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees. If Executive shall die while any amounts would be payable to Executive hereunder had Executive continued to live, all such amounts, unless otherwise provided herein, shall be paid in accordance with the terms of this Agreement to such person or persons appointed in writing by Executive to receive such amounts or, if no person is so appointed, to Executive's estate.

13. Limitation on Payments.

A. Notwithstanding any other provisions of this Agreement, in the event that any payment or benefit received or to be received by Executive (including any payment or benefit received in connection with a Change in Control or the termination of Executive's employment, whether pursuant to the terms of this Agreement or any other plan, arrangement or agreement) (all such payments and benefits, including the payments and benefits under Section 9 hereof, being hereinafter referred to as the "Total Payments") would be subject (in whole or part), to the excise tax imposed under Section 4999 of the Internal Revenue Code of 1986, as amended (the "Code") (the "Excise Tax"), then, after taking into account any reduction in the Total Payments provided by reason of Section 280G of the Code in such other plan, arrangement or agreement, the cash severance payments shall first be reduced, and the non-cash severance payments shall thereafter be reduced, to the extent necessary so that no portion of the Total Payments is subject to the Excise Tax, but only if (i) the net amount of such Total Payments, as so reduced (and after subtracting the net amount of federal, state and local income taxes on such reduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such reduced Total Payments), is greater than or equal to (ii) the net amount of such Total Payments without such reduction (but after subtracting the net amount of federal, state and local income taxes on such Total Payments and the amount of Excise Tax to which Executive would be subject in respect of such unreduced Total Payments and after taking into account the phase out of itemized deductions and personal exemptions attributable to such unreduced Total Payments). The Total Payments shall be reduced by the Company in its reasonable discretion in the following order: (A) reduction of any cash severance payments otherwise payable to Executive that are exempt from Section 409A (as defined below), (B) reduction of any other cash payments or benefits otherwise payable to Executive that are exempt from Section 409A, but excluding any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A, (C) reduction of any other payments or benefits otherwise payable to Executive on a pro-rata basis or such other manner that complies with Section 409A, but excluding any payments attributable to the acceleration of vesting and payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A, and (D) reduction of any payments attributable to the acceleration of vesting or payments with respect to any stock option or other equity award with respect to the Company's Common Stock that are exempt from Section 409A.

B. For purposes of determining whether and the extent to which the Total Payments will be subject to the Excise Tax, (i) no portion of the Total Payments the receipt or enjoyment of which Executive shall have waived at such time and in such manner as not to constitute a "payment" within the meaning of Section 280G(b) of the Code shall be taken into account, (ii) no portion of the Total Payments shall be taken into account which, in the written opinion of independent auditors of nationally recognized standing ("Independent Advisors") selected by the Company, does not constitute a "parachute payment" within the meaning of Section 280G(b)(2) of the Code (including by reason of Section 280G(b)(4)(A) of the Code) and, in calculating the Excise Tax, no portion of such Total Payments shall be taken into account which, in the opinion of Independent Advisors, constitutes reasonable compensation for services actually rendered, within the meaning of Section 280G(b)(4)(B) of the Code, in excess of the "base amount" (as defined in Section 280G(b)(3) of the Code) allocable to such reasonable compensation, and (iii) the value of any non-cash benefit or any deferred payment or benefit included in the Total Payments shall be determined by the Independent Advisors in accordance with the principles of Sections 280G(d)(3) and (4) of the Code.

14. Section 409A of the Internal Revenue Code. It is the intention of the Company and Executive that this Agreement not result in unfavorable tax consequences to Executive under Section 409A of the Code, and the Treasury Regulations and Internal Revenue Service guidance promulgated thereunder ("Section 409A") and the Agreement shall be interpreted, construed and administered as to so comply with, or be exempt from, Section 409A. Notwithstanding anything to the contrary herein, the Company and Executive agree to the provisions set forth in this Section 14 in order to comply with, or be exempt from, the requirements of Section 409A.

A. If Executive is a "specified employee" (as determined under the Company's Specified Employee Policy as in effect from time to time, or, in the absence of such policy, within the meaning of Section 409A) with respect to the Company, any non-exempt non-qualified deferred compensation that is subject to Section 409A and otherwise payable to or in respect of Executive in connection with Executive's Separation from Service pursuant to this Agreement shall be delayed until the earlier of (i) the expiration of six (6) months measured from the date of Executive's Separation from Service, or (ii) the date of Executive's death. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

B. All incentive bonus payments described in Section 6(D) shall be paid to Executive, to the extent earned, in no event later than the last day of the "applicable 2-1/2 month period", as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

C. With respect to the Company's reimbursement obligations under Sections 6(C) and 6(E) hereof and the provision of benefits to Executive, (i) in no event shall any such reimbursements or in-kind benefits be made or provided later than the last day of Executive's taxable year following the taxable year in which the fee or expense was incurred, (ii) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during Executive's taxable year may not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year of Executive, and (iii) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit, in accordance with Treasury Regulation Section 1.409A-3(i)(1)(iv).

D. The Company and Executive agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by Executive due to any failure to comply with Section 409A. To the extent payments and benefits under this Agreement are subject to Section 409A, and such payments and benefits do not so comply, the Company shall amend this Agreement, or take such other actions as the Company deems reasonably necessary or appropriate, to comply with Section 409A. If any provision of the Agreement would cause such payments and benefits to fail to so comply, such provision shall not be effective and shall be null and void with respect to such payments or benefits, and such provision shall otherwise remain in full force and effect.

15. Company Policies. Executive's employment with the Company is subject to the terms and conditions contained in the Company's Associate Policies, including those located on HR Link, which can be accessed through the Company's intranet site, as in effect from time to time (the "Associate Policies"), the content of which is incorporated by reference herein. Executive shall be required to read, understand and comply with the Associate Policies.

16. Compensation Recovery (Clawback). Notwithstanding anything in this Agreement to the contrary, any compensation payable to Executive under this Agreement that constitutes "Incentive Compensation" (as such term is defined under the Company's Compensation Recovery Policy, as such policy may be amended from time to time (the "Compensation Recovery Policy")) shall be subject to the terms and conditions of the Compensation Recovery Policy.

17. Severability. If any term of this Agreement is held to be invalid, void or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected and the parties shall use their best efforts to find an alternative way to achieve the same result.

18. Integrated Agreement. This Agreement supersedes any prior agreements, representations or promises of any kind, whether written, oral, express or implied between the parties hereto with respect to the subject matters herein, including the Prior Agreement. It constitutes the full, complete and exclusive agreement between Executive and the Company with respect to the subject matters herein. This Agreement cannot be changed unless in writing, signed by Executive and a duly authorized officer of the Company and approved by the Board of Directors of the Company (or the Committee or its delegate, if permitted by the Committee's charter). The Company acknowledges and agrees that nothing contained herein shall be deemed to supercede, amend or otherwise modify the terms of the Indemnification Agreement dated November 15, 2008 between Executive and the Company.

19. Waiver. No waiver of any default hereunder shall operate as a waiver of any subsequent default. Failure by either party to enforce any of the terms or conditions of this Agreement, for any length of time or from time to time, shall not be deemed to waive or decrease the rights of such party to insist thereafter upon strict performance by the other party.

20. Notices. All notices and communications required or permitted hereunder shall be in writing and shall be deemed given (a) if delivered personally, (b) upon confirmation of receipt by the sender after being sent by electronic mail, (c) one (1) business day after being sent by Federal Express or a similar commercial overnight service, or (d) three (3) business days after being mailed by registered or certified mail, return receipt requested, prepaid and addressed to the following

addresses, or at such other addresses as the parties may designate by written notice in the manner aforesaid:

If to the Company: Health Net, Inc.
21650 Oxnard Street, 22nd Floor
Woodland Hills, CA 91367
Attention: General Counsel

If to the Executive: Steve Tough
c/o Health Net, Inc.
2025 Aerojet Road
Rancho Cordova, CA 95742

21. Governing Law. The interpretation, construction and performance of this Agreement shall be governed by and construed and enforced in accordance with the internal laws of the State of Delaware without regard to the principle of conflicts of laws. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provisions of this Agreement, which other provisions shall remain in full force and effect.

22. Survival and Enforcement. Sections 3, 6(f), 8, 9, 11, 12, 13, 14 and 16 of this Agreement and any rights and remedies arising out of this Agreement shall survive and continue in full force and effect in accordance with the respective terms thereof, notwithstanding any termination of this Agreement or a Termination of Executive's employment. The parties agree that the Company would be damaged irreparably in the event any provision of Sections 3, 11 and 12 of this Agreement were not performed in accordance with its terms or were otherwise breached and that money damages would be an inadequate remedy for any such nonperformance or breach. Therefore, the Company or its successors or assigns shall be entitled in addition to other rights and remedies existing in their favor, to an injunction or injunctions to prevent any breach or threatened breach of any of such provisions and to enforce such provisions specifically (without posting a bond or other security).

23. Acknowledgement. Executive acknowledges that Executive has had the opportunity to discuss the content of this Agreement with and obtain advice from Executive's attorney, have had sufficient time to and have carefully read and fully understood all of the provisions of this Agreement, and Executive is knowingly and voluntarily entering into this Agreement. Executive further acknowledges that Executive is obligated to become familiar with and comply at all times with all written policies of the Company.

[Signature Page Follows]

Exhibit 10.10

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth above.

Executive	Health Net, Inc.
By: /s/ Steve Tough	By: /s/ Jay Gellert
Name: Steve Tough	Name: Jay Gellert
Title: President, Government Programs	Title: Chief Executive Officer and President

cc: Angelee Bouchard
Karin Mayhew
Debbie J. Colia/Steve Tough Personnel File

Exhibit 10.10

<u>EXHIBIT A</u>

FORM OF WAIVER AND RELEASE OF CLAIMS

This WAIVER AND RELEASE OF CLAIMS (this "Release" or "Agreement") is made and entered into by and between Health Net, Inc. and its affiliates and subsidiaries (hereinafter referred to as the "Company") and_____________ (hereinafter referred to as the "Employee").

WHEREAS, the Company and Employee are entering into this Release as a condition to Employee's receipt of severance pay upon his or her termination of employment with the Company.

NOW, THEREFORE, the Company and Employee agree as follows:

1. **Termination Date.** Employee's employment with the Company shall terminate on _______________ (the "Termination Date"). Following termination of employment, Employee shall not represent to anyone that he or she is an employee of the Company and shall not say or do anything purporting to bind the Company. For purposes of this Agreement, Employee will be entitled to receive the severance payment and benefits set forth under Section 2 hereof only to the extent Employee's termination of employment constitutes a "separation from service," as defined in Treasury Regulation Section 1.409A-1(h), and, in the event that Employee's "separation from service" occurs on a date other than the date set forth above, the "Termination Date" shall mean the date of Employee's "separation from service."

2. **Severance Benefits.** Provided that Employee signs and delivers this Agreement to the Company on or before the twenty-first (21st) day after Employee's receipt of this Agreement and does not revoke his/her acceptance within seven (7) days after signing this Agreement, the Company will provide Employee with the following benefits and payments, subject to the terms and conditions set forth in this Release:

   a. Employee shall be entitled to receive a lump sum severance payment under the terms of Employee's employment agreement or an applicable Company severance policy (as in effect from time to time) in the amount of $______ (which is equal to ____ months of Employee's monthly base salary in effect as of the date set forth in Section 1), subject to withholding for payroll taxes and applicable deductions. The severance payment will be made on the regular Company payday for the first payroll period beginning after the Effective Date as defined in Section 4(d)(vi), and in no event later than March 15 following the calendar year in which the Termination Date occurs.

   In the event that the Company rehires Employee and the number of months between Employee's Termination Date and the date of his or her re-hire, if any, is less than the number of months of Employee's monthly base salary that was taken into account to calculate his or her lump sum severance payment, then the

Employee shall repay to the Company an amount equal to the amount of his or her severance payment multiplied by a fraction, the numerator of which is the number of months on which the severance payment was based, minus the number of months (any partial month will be prorated) during which the Employee was unemployed by the Company, and the denominator of which is the number of months on which the severance payment was based (e.g. if an employee receives three months of severance pay and is re-hired by the Company two months after his or her Termination Date, he or she will be required to repay to the Company an amount equal to one month of severance pay.) In addition, upon re-hire the COBRA premium benefits set forth in Section 2(b) will cease when Employee becomes eligible as an employee for benefits under the Company's group health, vision and dental plans.

In further consideration for the Employee's acceptance of this Agreement, the Company will provide outplacement services to the Employee rendered by Lee Hecht Harrison per the Company's outplacement service program in effect as of the date of this Agreement. The Employee must enroll in the outplacement service program with Lee Hecht Harrison within sixty (60) days of the Employee's Termination Date in order to be eligible to receive these outplacement service benefits. To the greatest extent applicable, such outplacement services shall be provided in a manner that is exempt from Section 409A of the Internal Revenue Code of 1986, as amended, and the Treasury Regulations and Internal Revenue Service guidance thereunder ("Section 409A") in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(A). In the event that the outplacement services constitute nonqualified deferred compensation subject to Section 409A of the Code, the outplacement services shall be provided in a manner that complies with Section 409A of the Code and the provisions of Section 19 hereof.

b. Effective as of the first day of the month immediately following the month in which the Termination Date occurs, Employee and Employee's spouse/life partner and dependents who are covered under the Company's employee welfare benefit plan which is a group health plan immediately prior to the Termination Date shall be eligible to elect to continue coverage under such plan, as required under and in accordance with Part VI ("COBRA") of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). If the appropriate COBRA election forms are completed, signed and returned by the applicable deadlines established by the Company, the Company shall pay on the Employee's behalf the full cost of the COBRA coverage for group health plan and dental and vision benefits as employee had in effect immediately prior to the Termination Date under such plan until the earlier of (i) the end of ______ months from the Termination Date and (ii) the date Employee becomes eligible for coverage under a plan of another employer. If the group health, dental or vision benefit elected by Employee is replaced or becomes unavailable, the Company will pay for coverage under the replacement benefit or, if a benefit is not replaced, the most similar plan remaining in effect. If, upon the termination of the Company's payment of such

COBRA coverage, Employee continues to be entitled under federal law to receive COBRA coverage, then any such coverage shall be available to Employee, solely at Employee's expense, at the full COBRA coverage rates then in effect. COBRA election forms will be mailed to Employee's home address under separate cover. To the greatest extent applicable, such continued health coverage shall be provided in a manner that is exempt from Section 409A in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(B).

3. **Acknowledgements**.

a. Employee acknowledges and agrees that the payments and benefits set forth in Sections 2(a) and (b) above are payments and benefits to which Employee is not otherwise entitled, and Employee understands that if he or she does not sign this Release, or if he or she revokes acceptance of this Release, Employee shall not be entitled to these payments and benefits.

b. By signing below, Employee confirms and agrees that as of the Termination Date, Employee has been paid, or will be paid in his or her final regular paycheck (subject to withholding for taxes and applicable deductions), all accrued salary, unused accrued Paid Time Off, and other similar payroll related benefits and compensation due the Employee as of the Termination Date by virtue of his or her employment, in keeping with the Company's policy and practice. Employee further acknowledges that no other compensation or wages are due and owing to Employee, and no further Paid Time Off or other benefits will accrue after the Termination Date.

c. Employee's participation in all Company employee benefit plans as an active employee shall cease on the Termination Date, and Employee shall not be eligible to make contributions to or to receive additional Company contributions under the Health Net, Inc. 401(k) Associate Savings Plan, (the "401(k) Plan") (other than any "supplemental Matching Contributions" made pursuant to the 401(k) Plan) or to make any deferrals pursuant to any deferred compensation plan of the Company after the Termination Date. All payments due Employee under employee benefit plans or arrangements in which Employee participates, including without limitation, the 401 (k) Plan and any deferred compensation plan of the Company, shall be paid to Employee pursuant to the terms and provisions of such plans. Notwithstanding the foregoing, if, immediately prior to the Termination Date, Employee participates in certain Company employee welfare benefit plans, Employee's participation in such plans may continue on the same terms and conditions, including the same co-payment terms, until the last day of the month in which the Termination Date occurs.

4. **Release.**

a. *General Release*. In return for the consideration set forth in Sections 2(a) and (b) above, Employee, on behalf of himself or herself, as well as Employee's heirs, beneficiaries, successors, representatives, trustees, administrators and assigns, freely and voluntarily hereby waives and releases the Company, and each of its past, present and future officers, directors, shareholders, employees, consultants, accountants, attorneys, agents, managers, insurers, sureties, parent and sister corporations, divisions, subsidiary corporations and entities, partners, joint venturers and affiliates (and each of their respective beneficiaries, successors, representatives and assigns) and all persons acting in concert with them (collectively, "Affiliates") from any and all claims, demands, damages, debts, liabilities, controversies, obligations, actions or causes of action of any nature whatsoever, whether based on tort, statute, contract, indemnity, rescission or any other theory of recovery, and whether for compensatory, punitive, equitable or other relief, whether known, unknown, suspected or unsuspected, against the Company and/or its Affiliates, including without limitation claims which may have arisen or may in the future arise in connection with any event that occurred on or before the date of Employee's execution of this Release.

These claims include but are not limited to claims arising under federal, state and local statutory or common law, including, but not limited to the Age Discrimination in Employment Act, 29 U.S.C. § 621 et seq. ("ADEA"); Title VII of the Civil Rights Act of 1964, as amended by the Civil Rights Act of 1991, 42 U.S.C. § 2000 et seq.; Equal Pay Act, 29 U.S.C. § 206(d); the Civil Rights Act of 1866, 42 U.S.C. § 1981; the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq.; the False Claims Act, 31 U.S.C. § 3729 et seq.; the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq.; the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2101 et seq.; the California Fair Employment and Housing Act, Cal. Lab. Code § 12940 et seq.; the California Equal Pay Law, Cal. Lab. Code §§ 1197.5(a),1199.5; the Moore-Brown-Roberti Family Rights Act of 1991, Cal. Gov't Code §§12945.2, 19702.3; the California WARN Act, Cal. Lab. Code § 1400 et seq.; the California Labor Code; the California Constitution; (all as amended) claims arising out of any legal restrictions on the Company's right to terminate its employees; or claims arising under state and federal whistleblower statutes to the maximum extent permitted by law. Nothing herein shall be construed to impede the employee from communicating directly with, cooperating with or providing information to any government regulator.

b. *Unknown Claims*. Employee expressly waives any right or claim of right to assert hereafter that any claim, demand, obligation and/or cause of action has, through ignorance, oversight or error, been omitted from the terms of this Release. Employee makes this waiver with full knowledge of his or her rights and with specific intent to release both his or her known and unknown claims, and therefore specifically waives his or her rights under Section 1542 of the Civil Code of California or other similar provisions of any other applicable law (collectively, "Section 1542"), which reads as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."

Employee understands and acknowledges the significance and consequence of this Release and of such specific waiver of Section 1542, and expressly agrees that this Agreement shall be given full force and effect according to each and all of its express terms and provisions, including those relating to unknown and unsuspected claims, demands, obligations and causes of action herein above specified.

c. *Claims Not Released*. This Release does not waive rights or claims under federal or state law that Employee cannot waive by private agreement, including, but not limited to those he or she may have under Sections 2800 and 2802 of the California Labor Code, the Employee's right to file a claim for unemployment benefits, worker's compensation benefits, claims under the Fair Labor Standards Act, health insurance benefits under COBRA, or claims with regards to vested benefits under a retirement plan governed by ERISA.

d. *Review and Revocation*. In accordance with the Older Workers Benefit Protection Act, Employee acknowledges and agrees this Agreement includes a waiver and release of all claims that Employee have or may have under the ADEA. With respect to the release of claims under the ADEA, Employee acknowledges that:

(i) This Agreement is written in a manner calculated to be understood by Employee and Employee understands it.

(ii) The waiver and release of claims under the ADEA contained in this Agreement does not cover rights or claims that may arise after the date on which Employee signs this Agreement.

(iii) This Agreement provides for consideration in addition to anything of value to which Employee is already entitled.

(iv) Employee is hereby advised to consult an attorney before signing this Agreement.

(v) Employee has been granted twenty-one (21) days after receiving this Agreement to decide whether or not to sign this Agreement. If Employee signs this Agreement prior to the expiration of the twenty-one (21) day period, Employee does so voluntarily and after having had the opportunity to consult with an attorney, and Employee hereby waives the remainder of the twenty-one (21) day period.

(vi) Employee has the right to revoke this Agreement within seven (7) days of signing this Agreement, and this Agreement shall not be enforceable or effective until the eighth (8th) day after he or she signs this Agreement (the "Effective Date").

(vii) In the event this Agreement is revoked, this Agreement will be null and void in its entirety, and Employee will not be entitled to the payments and benefits provided in Section 2 of this Agreement. If Employee wishes to revoke this Agreement, Employee must deliver written notice stating his or her intent to revoke this Agreement to the Company's ________________, on or before 5:00 p.m. on the seventh (7th) day after the date on which Employee signed this Agreement.

5. **No Future Actions.** To the extent permitted by law, Employee agrees that Employee shall not encourage, cooperate in, or initiate any suit or action of any kind, or voluntarily participate in same, individually or as a representative, witness or member of a class, under contract, law or regulation, federal, state or local, pertaining to any matter related to his or her employment with the Company. Employee represents that he or she has not, to date, initiated (or caused to be initiated) any such suit or action.

Employee agrees that if he or she, or anyone purporting to act on his or her behalf or under any assignment of claims from Employee, hereafter commences any suit arising out of, based upon, or relating to any of the claims released by the Agreement or in any manner asserts against the Company and/or its Affiliates, any of the claims released hereunder, then, to the maximum extent permitted by law, Employee will pay to the Company and/or its Affiliates, as applicable, in addition to any other damages caused to them thereby, all attorneys' fees incurred by the Company and/or its Affiliates, as applicable, in defending or otherwise responding to said suit or claim.

The foregoing shall not apply if Employee is required to participate by legal process or other requirement of applicable law, provided that Employee gives the Company notice if legal process is served on the Employee; or to any challenge by Employee to the validity of any release herein of ADEA claims or to any to suit or action brought by Employee to assert such a challenge.

Additionally, nothing in this Release precludes Employee from participating in any investigation or proceeding before any federal or state agency, or governmental body, including, but not limited to, the Equal Employment Opportunity Commission, the Securities and Exchange Commission, and/or the Department of Justice. However, while Employee may file a charge, provide information, or participate in any investigation or proceeding, by signing this Release, Employee, to the maximum extent permitted by law, waives any right to bring a lawsuit against the Company, and waives any right to any individual monetary recovery in any such proceeding or lawsuit or in any proceeding brought based on any communication by Employee to any federal, state or local government agency or department.

6. **Cooperation with the Company.** In addition, Employee shall, without further compensation, cooperate with and assist the Company in the investigation of, preparation for or defense of any actual or threatened third party claim, investigation or proceeding involving the Company or its predecessors or affiliates and arising from or relating to, in whole or in part, Employee's employment with the Company or its predecessors or affiliates for which the Company requests Employee's assistance, which cooperation and assistance shall include, but not be limited to, providing truthful testimony and assisting in information and document gathering efforts. In connection herewith, it is agreed that the Company will use its reasonable best efforts to assure that any request for such cooperation will not unduly interfere with Employee's other material business and personal obligations and commitments.

7. **Return of Company Property.** Employee agrees he or she shall return to the Company immediately upon termination of employment any building key(s), security pass or other access or identification cards and any and all Company property in his or her possession, including but not limited to any books, documents, credit cards, computer equipment, software, mobile phones or data files. Employee agrees to submit all expense accounts and to pay promptly the outstanding balance on each corporate credit card that the Company previously issued to Employee. Compliance with this Section is a condition precedent to the Company's obligation to provide the payments and benefits set forth in Section 2.

8. **Confidential Information.** To the maximum extent permitted by law, Employee shall not, without the Company's written consent by an authorized representative, at any time prior or subsequent to the execution of this Release, disclose, use, remove or copy any Confidential Information, trade secret or proprietary information he or she acquired during the course of his or her employment by the Company. "Confidential Information," for purposes of this Agreement, includes any information not previously published or generally in the public domain. Confidential Information, trade secrets and proprietary information includes without limitation, any technical, actuarial, economic, financial, procurement, provider, enrollee, customer, underwriting, contractual, managerial, marketing or other information of any type regarding the business in which the Company is engaged, but not including any previously published information or other information generally in the public domain. Employee also agrees that he or she shall not without the Company's written consent by an authorized representative, directly or

indirectly use the Company's trade secret information, including but not limited to customer lists, to solicit business of any customers of the Company (other than on behalf of the Company). Employee acknowledges and agrees that any "Invention," including without limitation, any developments or discoveries by Employee during the course of his or her employment with the Company through the date of execution of this Release resulting in patents, lists of customers, trade secrets, specialized know-how or other intellectual property useful in the then-current business of the Company and any original works of authority are the property of the Company and shall be used for the sole benefit of the Company. If not previously assigned to the Company, Employee hereby assigns ownership of any and all Inventions to the Company, provided, however, that the provisions of this Agreement requiring assignment of Inventions to the Company do not apply to any invention which qualifies fully under the provisions of California Labor Code section 2870, which provides as follows:

"(a) Any provision in an employment agreement which provides that an employee shall assign, or offer to assign, any of his or her rights in an invention to his or her employer shall not apply to an invention that the employee developed entirely on his or her own time without using the employer's equipment, supplies, facilities, or trade secret information except for those inventions that either:

(1) Relate at the time of conception or reduction to practice of the invention to the employer's business, or actual or demonstrably anticipated research or development of the employer; or

(2) Result from any work performed by the employee for the employer.

(b) To the extent a provision in an employment agreement purports to require an employee to assign an invention otherwise excluded from being required to be assigned under subdivision (a), the provision is against the public policy of this state and is unenforceable."

This provision shall supplement, but not limit or supersede any other agreement between Employee and the Company concerning any Confidential Information or other intellectual property.

9. **Non-Solicitation.** In addition to any other part or term of this Release, Employee agrees that he or she shall not, for a period of one (1) year from the date of this Agreement, regardless of the reason for Employee's termination of employment, without the Company's written consent by an authorized representative, on his or her own behalf or on behalf of any other person, either directly or indirectly, solicit, recruit, encourage or induce any employee, agent, provider, vendor or independent contractor with whom Employee became acquainted during the course of employment to terminate such a person's or entity's relationship with the Company or to associate with a competitor of the Company. The prohibitions of this paragraph are not intended to deny employment opportunities within the Employee's field of employment but are limited only to those prohibitions necessary to protect the Company from unfair competition.

10. **No Disparagement.** Employee further agrees and acknowledges that in exchange for the consideration identified in Sections 2 (a) and (b) above, he or she shall not make any disparaging comments and/or statements to anyone either orally or in writing about the Company and/or its employees.

11. **No Admission.** Nothing contained herein shall be construed as an admission of any wrongful act, including, but not limited to, violation of any contract, express or implied, or any federal, state or local employment laws or regulations, and nothing contained herein shall be used for any purpose except in proceedings related to the enforcement of this Release.

12. **Arbitration of Disputes.** If there is any dispute between the Company and the Employee over the terms or obligations under this Release, that dispute shall be resolved by binding arbitration before a single neutral arbitrator who shall be a retired judge. The arbitration shall proceed in accordance with the then-current Employment Rules of the American Arbitration Association. The judgment of the arbitrator shall be final, binding and nonappealable, and may be entered in any state or federal court having jurisdiction thereafter. The arbitrator shall be bound to apply and follow the applicable state or federal laws in reaching a decision in this matter. Any disagreement regarding whether a dispute is required to be arbitrated pursuant to this Release shall be decided by the arbitrator. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, shall govern the interpretation and enforcement of this paragraph.

Notwithstanding the above paragraph, the arbitration procedure shall not prohibit Employee or the Company from seeking injunctive relief, including without limitation, temporary or preliminary injunctive relief, through any court of competent jurisdiction if such relief is not available or is not available in a timely manner, through arbitration.

13. **Confidentiality.** Employee represents and agrees that he or she will keep the terms, amounts and facts of this Release completely confidential, and that he or she will not hereafter disclose any information concerning this Release to anyone except his or her immediate family, attorneys or accountants or taxing authorities, except as may be required by law. Employee agrees that if Employee discloses this Release to anyone in his or her immediate family, his or her attorney(s), or his or her accountant(s), Employee will ensure that the individual to whom Employee discloses the Agreement understands that he or she is also subject to this confidentiality provision. Employee agrees that he or she is liable for any breach of this provision by his or her immediate family, attorney(s) or accountant(s), in the same manner and with the same consequences as if the Employee himself/herself had breached this provision. This provision shall not apply to any information that becomes generally known as a result of disclosure by the Company.

14. **Severability.** Should any part, term or provision of this Release be declared and/or be determined by any court or arbitrator to be illegal or invalid, the validity of the remaining parts, terms or provisions shall not be affected thereby, and said illegal or invalid part, term or provision shall be deemed not to be a part of this Release.

15. **Entire Agreement/No Oral Modification.** This Release contains the entire agreement between the parties hereto, and fully supersedes any and all prior agreements or understandings between the parties hereto pertaining to the subject matter hereof. There may be no modification of the terms of this Release except in writing signed by the parties hereto.

16. **Opportunity to Consult with Counsel.** Employee acknowledges that he or she has had an opportunity to consult with and be represented by counsel of Employee's choosing in the review of this Release, that he or she has been advised by the Company to do so, that the Employee is fully aware of the contents of the Release and of its legal effect, that the preceding paragraphs recite the sole consideration for this Release, and that Employee enters into this Release freely, without duress or coercion, and based on the Employee's own judgment and wishes and not in reliance upon any representation or promise made by the Company, other than those contained herein.

17. **Choice of Law.** Except as otherwise stated herein, this Release shall in all respects be interpreted, enforced and governed under the laws of the State of California. The language of all parts of this Release shall in all cases be construed as a whole, according to its fair meaning, and not strictly for or against any of the parties.

18. **Reformation.** In the event any part, term or provision herein is not enforceable including because its geographic scope, length or subject matter is determined to be excessive, then such part, term or provision shall be reformed to the minimum extent necessary to make such part, term or provision enforceable.

19. **Outplacement and Section 409A.** To the extent that the outplacement services provided under Section 2(a) and/or the continued health benefits payable under Section 2(b) constitute non-exempt "nonqualified deferred compensation" (within the meaning of Section 409A) that is subject to Section 409A, such benefits shall be provided in a manner that complies with the requirements of Treasury Regulation Section 1.409A-3(i)(1)(iv), including, without limitation, the following conditions: (i) the benefits payable in Employee's taxable year may not affect such benefits that Employee is eligible to receive in another taxable year of Employee; (ii) the reimbursement of expenses or provision of in-kind benefits shall be made on or before the last day of Employee's taxable year following the taxable year in which the expense or obligation is incurred; and (iii) such benefits shall not be subject to liquidation or exchange for another benefit.

20. **Headings.** The headings of the Sections of this Agreement are provided for convenience only. They do not alter or limit, in any way, the text of any Section of this Agreement.

21. **Acceptance and Expiration.** Employee has up to twenty-one (21) calendar days from the date he or she receives this document to consider and accept the terms of this Release, but may accept it at any time within those twenty-one (21) calendar days. Employee agrees that changes to the terms or form of this Release, whether material or immaterial do not restart the running of the twenty-one (21) day period. After twenty-one (21) calendar days have passed, this offer will expire.

Exhibit 10.10

EMPLOYEE ACKNOWLEDGES BY SIGNING BELOW that (i) Employee has not relied upon any representations, written or oral, not set forth in this Release; (ii) at the time Employee was given this Release, Employee was informed in writing by the Company that: (a) Employee had at least twenty-one (21) calendar days in which to consider whether Employee would sign the Release; (b) Employee was advised to consult with an attorney before signing the Release; and (c) Employee had seven (7) calendar days to revoke this Agreement after signing it; (iii) Employee had an opportunity to consult with an attorney and either had such consultations or has freely decided to sign this Release without consulting an attorney; and (iv) Employee executes this Release knowingly and voluntarily.

IN WITNESS WHEREOF, the parties hereto have executed this Release as of the dates set forth below.

Employee Health Net, Inc.

By: By: ______________________________
Name: Name:
Title:

Dated: Dated: ____________________________

NOTE: Please return your signed waiver and release to:
Organization Effectiveness Unit
Attention: (Name, Title)
(Address, City, State, Zip Code)

Exhibit 10.25

FORM OF PERFORMANCE SHARE AWARD AGREEMENT

This Performance Share Award Agreement, including Appendix I attached hereto, (together with the Notice of Grant of Performance Share Award (the "Grant Notice") attached hereto and incorporated by reference herein, the "Performance Share Award Agreement") is made and entered into as of the grant date set forth on the Grant Notice (the "Date of Grant"), by and between Health Net, Inc., a Delaware corporation (the "Company"), and the recipient identified on the Grant Notice, an employee of the Company or a subsidiary of the Company (the "Recipient").

WHEREAS, the Compensation Committee (the "Committee") of the Board of Directors (the "Board") of the Company, and if applicable, the Board, has approved the grant (the "Grant") of a performance share award to the Recipient as set forth below under the Company's 2006 Long-Term Incentive Plan, as amended from time to time (the "Plan"). Capitalized terms used but not defined herein shall have the meanings set forth in the Plan.

NOW, THEREFORE, in consideration of the covenants and agreements herein contained and intending to be legally bound hereby, the parties agree as follows:

1. Grant of Performance Shares. The Company hereby grants to the Recipient a performance share award consisting of the target number set forth on the Grant Notice (the "Target Award") of rights to receive ("Performance Shares"), upon vesting, a share of the Common Stock, par value $.001 per share, of the Company (the "Common Stock"), subject to all of the terms and conditions of this Performance Share Award Agreement. The actual number of shares earned by the Recipient may differ from the Target Award, as further described herein.

2. Vesting. Except as otherwise provided in Section 3 and Section 10 hereof, the Performance Shares shall vest as set forth on Appendix I.

3. Termination of Employment.

(a) If Recipient's employment with the Employer is terminated by either the Recipient or the Employer for any reason (a "Termination Event") prior to a Change in Control (as defined in the Plan), then all unvested Performance Shares shall be immediately forfeited at such time.

(b) If the Recipient experiences a Termination for Good Reason (as the concept is defined in the Recipient's employment agreement with the Company (the "Employment Agreement"), or if the Recipient does not have an Employment Agreement or Recipient's Employment Agreement does not include a definition for the concept of Good

Reason, Good Reason shall be as defined in the Company's Severance Policy, as it may be amended from time to time, the "Severance Policy") or a termination by the Employer without Cause (as defined in the Employment Agreement, or if the Recipient does not have an Employment Agreement or Recipient's Employment Agreement does not include a definition for the concept of Cause, Cause shall be as defined in the Severance Policy), on or following a Change in Control, then all unvested Performance Shares shall immediately become fully vested and distributable on the date of such termination of employment.

(c) If the Recipient violates the terms of Section 4 of this Performance Share Award Agreement (a "Breach Event"), in addition to being subject to all remedies in law or equity that the Company may assert, then at any time thereafter the Company, in its sole and absolute discretion, may, with respect to any Common Stock attributable to a Performance Share: (i) to the extent that the Common Stock is beneficially owned by the Recipient, reacquire from the Recipient, in return for an amount equal to the par value of the Common Stock, any or all of the shares of such Common Stock; and (ii) to the extent that the Common Stock has been sold, assigned or otherwise transferred by the Recipient, recover from the Recipient an amount equal to the Gain Realized (as defined in Section 4 below) from such sale, assignment or transfer. Upon the occurrence of a Breach Event, the Company may elect to purchase all or any portion of the Common Stock pursuant to this Section 3(c) by delivery of written notice to the Recipient within ninety (90) days after the Company becomes aware of the occurrence of such Breach Event.

4. Employment/Association with Company Competitor. The Recipient hereby agrees that, during (i) the six-month period following a termination of the Recipient's employment with an Employer that entitles the Recipient to receive severance benefits under an agreement with or the policy of the Company or an Employer or (ii) the twelve-month period following a termination of the Recipient's employment with an Employer that does not entitle the Recipient to receive such severance benefits (the period referred to in either clause (i) or (ii), the "Noncompetition Period"), the Recipient shall not undertake any employment or activity (including, but not limited to, consulting services) with a Competitor (as defined below), where the loyal and complete fulfillment of the duties of the competitive employment or activity would call upon the Recipient to reveal, to make judgments on or otherwise use any confidential business information or trade secrets of the business of the Company or any Subsidiary to which the Recipient had access during the Recipient's employment with the Employer. In addition, the Recipient agrees that, during the Noncompetition Period applicable to the Recipient following termination of employment with the Employer, the Recipient shall not, directly or indirectly, solicit, interfere with, hire, offer to hire or induce any person, who is or was an employee of the Company or any of its Subsidiaries during the 12 month period prior to the date of such termination of employment, to discontinue his or her relationship with the Company or any of its

Subsidiaries or to accept employment by, or enter into a business relationship with, the Recipient or any other entity or person. In the event that the Recipient breaches the covenants set forth in this first paragraph of Section 4, it shall be considered a Breach Event under Section 3 above.

"Gain Realized" shall equal the difference between (x) the par value paid by the Recipient for the Common Stock issued in respect of the Performance Shares and (y) the greater of the Fair Market Value (as defined in the Plan) of the Common Stock issued in respect of the Performance Shares (I) on the date of transfer of such Common Stock or (II) on the date such competitive activity with a Competitor was commenced by the Recipient; and "Competitor" shall refer to any health maintenance organization or insurance company that provides managed health care or related services similar to those provided by the Company or any Subsidiary.

It is hereby further agreed that if any court of competent jurisdiction shall determine that the restrictions imposed in this Section 4 are unreasonable (including, but not limited to, the definition of Competitor or the time period during which this provision is applicable), the parties hereto hereby agree to any restrictions that such court would find to be reasonable under the circumstances.

The Recipient acknowledges that the services to be rendered by the Recipient to the Company are of a special and unique character, which gives this Performance Share Award Agreement a peculiar value to the Company, the loss of which may not be reasonably or adequately compensated for by damages in an action at law, and that a material breach or threatened breach by the Recipient of any of the provisions contained in this Section 4 will cause the Company irreparable injury. Recipient therefore agrees that the Company may be entitled, in addition to the remedies set forth above in this Section 4 and any other right or remedy, to a temporary, preliminary and permanent injunction, without the necessity of proving the inadequacy of monetary damages or the posting of any bond or security, enjoining or restraining Recipient from any such violations or threatened violations.

4A. Compensation Recovery (Clawback). In the event that Recipient is subject to the Company's Compensation Recovery Policy, as such policy may be amended from time to time (the "Compensation Recovery Policy"), notwithstanding anything in this Performance Share Award Agreement to the contrary, any Performance Shares granted, or Common Stock attributable to a Performance Share, hereunder shall be subject to the terms and conditions of the Compensation Recovery Policy.

5. No Rights as a Stockholder. The Recipient shall not be entitled to dividends, if any, that are paid with respect to the shares of Common Stock unless and until the Performance Shares have vested and shares of Common Stock have been delivered with respect thereto. Recipient shall also not have the right to vote any shares subject to the Performance

Shares unless and until the Performance Shares shall have vested and shares of Common Stock have been delivered with respect thereto.

6. Notices. Any notice or communication given hereunder shall be in writing and shall be given electronically (*e.g.*, email) or by fax or first class mail, certified or registered with return receipt requested, and shall be deemed to have been duly given three (3) days after first class mailing or twenty-four (24) hours after transmission of an email or a fax to the following addresses:

To the Recipient at: Address on record at Health Net, Inc. as of the date any notice is to be delivered.

To the Company at: Health Net, Inc.
21650 Oxnard Street
Woodland Hills, California 91367
Attention: General Counsel

or to such other address as any party may have furnished to the other in writing in accordance herewith, except that notices of change of address shall be effective only upon receipt.

7. Securities Laws Requirements. The Company shall not be obligated to transfer any shares of Common Stock from the Recipient to another party, if such transfer, in the opinion of counsel for the Company, would violate the Securities Act of 1933, as amended from time to time (the "Securities Act") (or any other federal or state statutes having similar requirements as may be in effect at that time). Further, the Company may require as a condition of transfer of any shares to the Recipient that the Recipient furnish a written representation that he or she is holding the shares for investment and not with a view to resale or distribution to the public. The Company either has or will file an appropriate registration statement on Form S-8 (or other applicable form), and has taken or will take such actions as necessary to keep the information therein current from time to time, in order to register the Common Stock under the Securities Act and shall use its commercially reasonable efforts to cause such registration statement to become effective and to maintain the effectiveness of such registration.

8. Protections Against Violations of Performance Share Award Agreement. This Performance Share Award Agreement is not transferable, other than by will or pursuant to the laws of descent and distribution.

9. Taxes. The Recipient understands that he or she (and not the Company) shall be responsible for any tax obligation that may arise as a result of the transactions contemplated by this Performance Share Award Agreement and shall pay to the Company, in any method as set forth in Section 8.6 of the Plan, the amount determined by the Company to be such

tax obligation at the time such tax obligation arises. Such tax obligation shall be satisfied through the withholding of shares by the Company or such other manner as determined by the Company in its sole discretion. If the Recipient fails to make such payment, the number of shares necessary to satisfy the tax obligations shall be forfeited.

10. Change in Control. Notwithstanding anything to the contrary herein, in the event that the Company enters into a definitive agreement during the performance period as set forth on Appendix I with a third party to consummate a transaction that would result in a Change in Control, (i) if such Change in Control occurs before the date the Compensation Committee would normally determine whether the performance goal set forth on Appendix I has been achieved, then each outstanding Performance Share will be deemed earned immediately upon the occurrence of the Change in Control as if the Target Performance Level had been achieved as of the date of the Change in Control and (ii) if such Change in Control has not occurred before the date the Compensation Committee would normally determine whether the performance goal set forth on Appendix I has been achieved, then the Compensation Committee will have the discretion to determine the performance level achieved as of the end of the performance period set forth on Appendix I, taking into account its determination of the impact that (a) the announcement of the Change in Control transaction and (b) the operation of the business in light of the pending Change in Control transaction had on the Company's ability to achieve the Target Performance Level. In either such event, the Performance Shares deemed or determined to have been earned will continue to vest over the remaining Time-Vesting Schedule (as defined in Appendix I, attached hereto, with the date the Compensation Committee determines the performance level achieved or the date of the Change in Control (if earlier) as the "Determination Date"), subject to the Recipient's continued employment with the Company's successor; provided, however, that if, on or after the Change in Control, the Recipient's employment is terminated without Cause or the Recipient resigns for Good Reason, all of the Performance Shares will immediately become fully vested and distributable on the date of such termination of employment pursuant to Section 3(b) hereof.

11. Failure to Enforce Not a Waiver. The failure of the Company to enforce at any time any provision of this Performance Share Award Agreement shall in no way be construed to be a waiver of such provision or of any other provision hereof.

12. Governing Law. This Performance Share Award Agreement shall be governed by and construed according to the laws of the State of Delaware without regard to its principles of conflict of laws.

13. Amendments. This Performance Share Award Agreement may be amended or modified at any time by the Committee; provided, however, that the amendment or modification of this Performance Share Award Agreement shall not, without the consent of the

Recipient, adversely affect the rights of the Recipient under this Performance Share Award Agreement. The Board may terminate or amend the Plan at any time; provided, however, that the termination or any modification or amendment of the Plan shall not, without the consent of the Recipient, impair the rights of the Recipient under this Performance Share Award Agreement.

14. Survival of Terms. This Performance Share Award Agreement shall apply to and bind the Recipient and the Company and their respective permitted assignees and transferees, heirs, legatees, executors, administrators and legal successors.

15. Agreement Not a Contract for Services; Rights to Terminate Employment. Neither the grant of the Performance Shares, this Performance Share Award Agreement nor any other action taken pursuant to this Performance Share Award Agreement shall constitute or be evidence of any agreement or understanding, express or implied, that the Recipient has a right to continue to provide services as an officer, director, employee or consultant of the Company and/or the Employer for any period of time or at any specific rate of compensation. Nothing in the Plan or in this Performance Share Award Agreement shall confer upon the Recipient the right to continue in the employment of an Employer or affect any right which an Employer may have to terminate the employment of the Recipient. The Recipient specifically acknowledges that the Employer intends to review the Recipient's performance from time to time, and that the Company and/or the Employer has the right to terminate the Recipient's employment at any time, including a time in close proximity to any Vesting Date, for any reason, with or without cause. Except as set forth in Section 3 and 10, the Recipient acknowledges that upon his or her termination of employment with an Employer for any reason, then all unvested Performance Shares shall be immediately forfeited at such time.

16. Decisions of Board or Committee. The Board or the Committee shall have the right to resolve all questions which may arise in connection with this Performance Share Award Agreement or the Performance Shares. Any interpretation, determination or other action made or taken by the Board or the Committee regarding the Performance Shares, the Plan or this Performance Share Award Agreement shall be final, binding and conclusive.

17. Failure to Execute Agreement. This Performance Share Award Agreement and the Performance Shares granted hereunder are subject to the Recipient returning a counter-signed copy of this Performance Share Award Agreement to the designated representative of the Company on or before the [____] day after the Date of Grant (except as otherwise determined by the Compensation Committee of the Company or a subcommittee thereof in its sole discretion). In the event that the Recipient fails to so return a counter-signed copy of this Performance Share Award Agreement within such period, then this Performance Share Award Agreement and the Performance Shares granted hereunder shall automatically become null and void and shall have no further force or effect. Electronic acceptance of this Performance Share Award Agreement

Exhibit 10.25

shall constitute an execution of the Performance Share Award Agreement by the Recipient and a return of the counter-signed copy to the Company.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Performance Share Award Agreement to be effective as of the Date of Grant.

Health Net, Inc.

Name:_____________
Title:

RECIPIENT HEREBY EXPRESSLY ACKNOWLEDGES AND AGREES THAT HE/SHE IS AN EMPLOYEE AT WILL AND MAY BE TERMINATED BY THE EMPLOYER AT ANY TIME, WITH OR WITHOUT CAUSE.

Your acceptance of this Performance Share Award Agreement indicates that you accept and agree to all the terms and provisions of the foregoing Performance Share Award Agreement and attached Grant Notice, and to all the terms and provisions of the Health Net, Inc. 2006 Long-Term Incentive Plan, as amended to date, incorporated by reference herein.

____

Name:

Exhibit 10.25

APPENDIX I

PERFORMANCE PERIOD,
VESTING AND PERFORMANCE GOALS

-

Exhibit 10.25

Notice of Grant of Performance Share Award
Health Net, Inc.

Plan Name: Health Net, Inc. 2006 Long-Term Incentive Plan, as amended

Recipient Name:

Recipient ID:

Grant Date:

Target Award:

Exhibit 10.60

FIRST AMENDMENT
TO THE
HEALTH NET, INC. 401(k) SAVINGS PLAN
(As Amended and Restated effective January 1, 2013)

WHEREAS, Health Net, Inc. (the "Company") has adopted the Health Net, Inc. 401(k) Savings Plan (the "Plan") for the benefit of its eligible employees of the Company and certain of its affiliates; and

WHEREAS, the Company desires to amend the Plan to remove the eligibility service requirement for employees scheduled to work fewer than 20 hours per week, to clarify the correction of error provision, to permit loan repayments following termination of employment and to revise the timing of distribution provisions, effective as of January 1, 2015.

NOW, THEREFORE, pursuant to the power of amendment contained in Section 15.1 of the Plan, the Plan is hereby amended, effective as of January 1, 2015, as follows:

1. Section 2(16) of the Plan is hereby amended in its entirety to read as follows:

(16) Eligible Employee. With respect to each Employer, unless specified otherwise by the board of directors of each Employer, an Eligible Employee is any Employee thereof, excluding:

(i) an Employee whose employment is governed by the terms of a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining, but which does not provide for participation in the Plan,

(ii) an Employee who is a nonresident alien (within the meaning of section 7701(b)(1)(B) of the Code), and

(iii) an Employee who is classified as a Special Professional Associate.

2. Section 7.6 of the Plan is hereby amended in its entirety to read as follows:

Section 7.6 Correction of Error. The Committee may correct errors made in the administration or operation of the Plan, as it deems necessary.

3. Section 8.3(c) of the Plan is hereby amended in its entirety to read as follows:

(c) Loan Repayments following Termination of Employment. In accordance with the procedures established by the 401(k) Administrator, a Participant who makes a timely election following his or her termination of employment may continue to repay an outstanding Plan loan following termination of employment.

Exhibit 10.60

4. Section 8.5(c) of the Plan is hereby amended in its entirety to read as follows:

(c) Time of Distribution. Except as provided in Sections 8.2(d) and 8.5(b), the Plan will pay a Participant (or Beneficiary, if applicable) a lump sum or a direct rollover as soon as administratively feasible after the Participant (or Beneficiary, if applicable) elects such distribution, *provided, however,* that:

(1) a Participant or Beneficiary may change the distribution election as of any Valuation Date by advance written notice to the Committee or its delegate before the distribution has been processed;

(2) no payments shall be made before the Participant's required beginning date unless the Participant has consented in writing;

(3) if a Participant has consented in writing, the Plan will make a distribution to such Participant in a lump sum or direct rollover (as elected) no later than 60 days after the end of the Plan Year which contains the latest of (A) the date of the Participant's termination of employment, (B) the 10th anniversary of the year in which the Participant began participating in the Plan and (C) the Participant's 65th birthday;

(4) this section and the distributions made hereunder shall be administered in accordance with section 401(a)(9) of the Code and the regulations promulgated thereunder, as set forth in Section 8.9;

(5) distributions commencing after the Participant's death shall be completed within five years after the death of the Participant, except that (i) if the Participant's Beneficiary is the Participant's Spouse, distribution may be deferred until the last day of the Plan Year in which the Participant would have attained age 70½ had he or she survived and (ii) if the Participant's Beneficiary is a natural person other than the Participant's Spouse and distributions commence not later than one year after the Participant's death, such distributions may be made over a period not longer than the life expectancy of such Beneficiary. If at the time of the Participant's death, distribution of the Participant's benefit has commenced, the remaining portion of the Participant's benefit shall be paid in the manner elected by the Participant's Beneficiary, but at least as rapidly as was the method of distribution being used prior to the Participant's death; and

(6) with respect to a Participant who continues in employment after attaining age 70½, distribution of the Participant's account balance shall commence no later than the Participant's required beginning date. For purposes of this paragraph, the term "required beginning date" shall mean (i) with respect to a Participant who is a 5%-owner (within the meaning of section 416(i) of the Code), April 1 of the calendar year following the calendar year in which the Participant attains age 70½ and (ii) with respect to any other Participant, April 1 of the calendar year following the calendar year in which the Participant retires. Distributions made under this paragraph shall be made in the form

of installment payments in the minimum amount required by section 401(a)(9) of the Code over the life expectancy of the Participant based on the Participant's age, or if applicable, the joint life expectancies of such Participant and the Participant's Spouse.

-

Exhibit 10.60

IN WITNESS WHEREOF, Health Net, Inc. has caused this instrument to be executed by its duly authorized officer this 17th day of November, 2014.

HEALTH NET, INC.

By: /s/ Karin D. Mayhew
Name: Karin D. Mayhew
Its: Senior Vice President
Organization Effectiveness

"*" = CONFIDENTIAL PORTIONS OF THIS DOCUMENT HAVE BEEN OMITTED AND HAVE BEEN SEPARATELY FILED WITH THE SECURITIES AND EXCHANGE COMMISSION PURSUANT TO AN APPLICATION FOR CONFIDENTIAL TREATMENT UNDER RULE 24B-2 UNDER THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED.**

**AMENDMENT NO. 5 TO
MASTER SERVICES AGREEMENT**

This Amendment No. 5 to Master Services Agreement ("***Amendment 5***") is made as of this November 02, 2014, by and between Cognizant Technology Solutions U.S. Corporation ("***Supplier***") and Health Net, Inc., a Delaware corporation ("***Health Net***") with reference to the following facts:

A. Supplier and Health Net entered into a Master Services Agreement dated September 30, 2008, as previously amended (collectively the "***Agreement***") which, among other things, requires Supplier to perform Services for Health Net.

B. Supplier and Health Net intend to enter into a separate agreement on or around the date of this Agreement under which Supplier will provide certain business process services for Health Net ("***BPaaS Agreement***").

C. In this Amendment 5, the parties desire to remove certain In-Scope Applications from the scope of this Agreement, transfer responsibility for them to Supplier under the BPaaS Agreement and modify certain other terms and conditions in the Agreement.

NOW, THEREFORE, in consideration of the mutual promises, covenants, agreements and other undertakings set forth herein and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

General Terms and Conditions

1. Defined terms used in this Amendment 5 shall have the same meaning as in the Agreement unless otherwise specifically defined herein. "BPaaS Services Commencement Date" shall have the meaning given in the BPaaS Agreement.

2. The modifications set forth in this Amendment 5 shall be effective on the "BPaaS Services Commencement Date". This Amendment 5 shall have no effect prior to such date, except for Section 10 which shall be effective March 1, 2015.

3. Section 4.2 of the Agreement is deleted in its entirety and replaced with the following:

"**4.2 Renewal Terms**
By giving notice to Supplier no less than three months prior to the then-existing expiration date of the Agreement, Health Net may extend the Term for a period designated by Health Net ***"

4. Section 24.2(b) of the Agreement is deleted in its entirety and replaced with the following:

"Except as provided in Section 24.2(c), each Party's total liability to the other, whether in contract or in tort () will be limited, in the aggregate, to the greater of (i) $*** and (ii) *** Service Level Credits do not count against and do not reduce the amounts available under the foregoing limitations. The limitations specified in this Section will survive and apply even if any limited remedy specified in this Agreement is found to have failed of its essential purpose. For purposes of this Section, fees shall be deemed payable when accrued to the benefit of and legally collectable by Supplier."

Schedule A

5. Exhibit A-4 (*In-Scope Applications*) is deleted in its entirety and replaced with the new version attached to this Amendment 5.

Schedule B

6. Section 4.4 of Schedule B is deleted in its entirety and replaced with the following:

". Service Level failures caused by Supplier's acts or omissions under the BPaaS Agreement shall not be excused under this Agreement."

7a. Notwithstanding anything to the contrary, for the period beginning on the BPaaS Services Commencement Date and continuing for *** years thereafter, the Amount at Risk shall be equal to the greater of (i) $*** and (ii) the amount determined under Section 6.2 of the Agreement.

7b. The Application Availability Service Levels in Exhibit B-1 (Service Levels ## 1-4) are deleted. The parties intend to measure availability of the In-Scope Applications under the Critical Service Availability Service Level provided in the IT SOW executed under the BPaaS Agreement. If the parties add a new In-Scope Application under this Agreement, they shall add it to the list of Critical Services under the IT SOW to the BPaaS Agreement.

Schedule C

8. The following Exhibits to Schedule C are deleted in their entirety and replaced with the new versions attached to this Amendment 5:

(a) Exhibit C-1: Production Support Charge
(b) Exhibit C-2: Individual Application Production Support Charge
(c) Exhibit C-6: T&M Rates
(d) Exhibit C-7: Skillset Mix and Supporting Skillset Rates

9. There are two Production Support Charges in Exhibit C-1. One compensates Supplier for Production Support Services for the HNFS Applications ("***HNFS Support Charge***"); the other compensates Supplier for Production Support Services for all other In-Scope Applications ("***Non-BPaaS Support Charge***"). Notwithstanding the inclusion of these charges in Exhibit C-1, the Non-BPaaS Support Charge shall not apply during the *** year period that begins on the BPaaS Commencement Date. Supplier shall remain responsible for providing the Production Support Services for all In-Scope Applications during such *** year period (in exchange for compensation received under the BPaaS Agreement).

10. Schedule X-1 to the BPaaS Agreement contains a list of Application Development Projects that Health Net has authorized Supplier to perform under the Agreement as of the date of this Agreement ("***In-Flight Projects***"). Supplier shall complete the In-Flight Projects under the Agreement in accordance with the applicable Project requirements and Service Levels. Supplier shall not, however, charge Health Net for any payment milestones *** for the In-Flight Projects. Supplier shall be fully compensated for performing the In-Flight Projects *** under this Agreement through charges provided in

the BPaaS Agreement. For clarification, this Section 10 shall not apply to Projects for HNFS applications that are not In-Flight Projects. Schedule X-2 to the BPaaS Agreement contains a separate list of "Accelerated Projects". These Accelerated Projects shall be performed under the BPaaS Agreement, regardless of whether they have been initiated under this Agreement. Health Net shall not be required to pay any amounts for the Accelerated Projects under the Agreement.

11. Section 4.4(a)(iii) (*Minor Enhancements*) of Schedule C (*Charges*) is deleted in its entirety and replaced with the following:

> "(iii) Beginning on the BPaaS Services Commencement Date, and continuing each Contract Year of the Term, the Baseline Minor Enhancement Hours shall equal *** hours per calendar quarter, unless adjusted pursuant to Section 4.4(b)."

12. Section 7.8 (Minimum Commitment) of Schedule C (*Charges*) is deleted in its entirety.

13. If the BPaaS Agreement is terminated during Phase 2 (as defined in the BPaaS Agreement), the parties will execute an amendment to this Agreement that (i) adds the In-Scope Applications that have been removed from the scope of this Agreement by this Amendment 5 back to the scope of this Agreement and (ii) reinstates the Production Support Charges applicable to such In-Scope Applications that have been removed by this Amendment 5.

Miscellaneous Terms

14. Except as amended and modified by this Amendment 5, all of the terms and conditions of the Agreement shall remain in full force and effect. This Amendment 5 may not be modified except in writing signed by both parties hereto. This Amendment 5, the Agreement and exhibits and schedules thereto constitute the entire agreement of the parties with respect to the subject matter contained therein and supersede any and all prior or contemporaneous agreements between the parties, whether oral or written, concerning the subject matter contained herein.

IN WITNESS WHEREOF, the parties hereto by their duly authorized representatives executed this Amendment 5 to be effective as of the date set forth in the Preamble.

COGNIZANT TECHNOLOGY SOLUTIONS U.S. CORPORATION	HEALTH NET, INC.
By /s/ Steven Schwartz	By /s/ James E Woys
Name Steven Schwartz	Name James E. Woys
Title Executive Vice President Chief Legal and Corporate Affairs Officer	Title EVP, COO & CFO

EXHIBIT A-4
IN-SCOPE APPLICATIONS

The table below identifies the In-Scope Applications. Application has the meaning set forth in Section 2.1(c) of the Terms and Conditions.

Application	Other Name	Scheduled Uptime (All PT)
ASPECT IVR - CA/OR		24x7
ASPECT IVR - NE/AZ		24x7
HNFS – AUTOCODER	HNFS - AutoCoder	24x6. Maintenance window: Sunday 12am PT - 7am PT
HNFS – CCS	HNFS - Medical Management System [Provider Finders, Automated Process Tracking and Inventory]	24x7. Planned maintenance only with official 24 hr notice to Government.
FARE		Mon - Fri: 06:00 - 22:00 Sat, Sun: 06:00 - 17:00
HNFS – FASTRIEVE	Fastrieve INFOrm	24x6. Maintenance window: Sunday 12am PT - 9am PT
HEALTHNETFEDERALSERVICES.NET	HNFS - HNFS.com/esHNFS.com [TPAPS, Provider Directory, PARB, Appeals and Grievances, OLARS, MTF/TSC Locator, HBA, IDP, DS Logon, VA Website, HRA]	24x7. Planned maintenance only with official 24 hour notice to Government.
HNFS - EDI	EDI HNFS	24x7. Planned maintenance only with official 24 hour notice to Government.
HNFS – LOTUS NOTES DATABASE	Lotus Notes Database HNFS	24x6 Maintenance window: Saturday 12am PT – 9pm PT
HYPERION		24x7
HNFS - JIVE	HNFS – JIVE [Unsupported Application] Running in JRE 1.6, KNOWLEDGE BASE - HNFS	24x7. Planned maintenance only with official 24 hour notice to Government.
LOTUS NOTES DATABASE		Sun - Fri: 24x6 Sat: 00:00 - 21:00
MG QUOTE	51/100	24x6. Maintenance window: 2ND Saturday 2100 – 0200

Application	Other Name	Scheduled Uptime (All PT)
PAOS		Mon - Sat: 02:30 - 20:00 Sun Unavailable
PEOPLESOFT		**DOWN TIMES:** Mon - Sat - 20:30 - 21:30 (image copies) Sun: 12:00 - Mon: 00:01 Payroll Mon: 12:00 - 23:59
SALSA		Mon - Fri: 24x7 (except 00:00 - 00:15) Sat: 00:15 - 21:00 Sun: 10:00 - 23:59
SAP		24x7
SBG		Mon - Fri: 24x7 (except 00:00 - 00:15) Sat: 00:15 - 21:00 Sun: 10:00 - 23:59
UNITY COMMERCIAL		24x7
UNITY/ATLANTES MHN		24x7
ARMS		Mon - Fri: 06:00 - 22:00 Sat, Sun: 06:00 - 17:00
CIVERPSYCH		24x7
ESSA		Mon – Fri: 07:00 to 20:00 Sat: 00:00 to 22:00 Sun: 06:00 to 23:59
FORMULARY AND BENEFITS - HNPS		Mon – Sat - 5:00AM to 19:00 PT
FORMULARY VIEWER - HNPS		Mon – Sat - 5:00AM to 20:00 PT
HNFS-QUANTUM	QUANTUM	24x7. Planned maintenance only with official 24 hour notice to Government.
HR LINK/AUTHORIA		7 X 24 (except Sun00:01 – 05:00 PT)
INPHARMATIVE-REBATEADMIN – HNPS		Mon – Sat - 6:00AM to 20:00 PT
HNFS - INTERQUAL	HNFS – InterQual (Review Manager)	24x6. Maintenance window: Sunday 12am PT - 9am PT
MFLC		24x7. Maintenance window: 2ND Saturday 2100 – 0200
MTM-RXCELLENT CARE - HNPS		Mon – Sat - 5:00AM to 20:00 PT

Application	Other Name	Scheduled Uptime (All PT)
PDE		24x6. Maintenance window: 2ND Saturday 2100 – 0200
RESOURCE IQ		24x7
HNFS - RRS (RETROSPECTIVE REVIEW SYSTEM)	TIBCO, Spotfire	24x6. Maintenance window: Sunday 12am PT - 7am PT
HNFS - WFA – STARS(WASTE, FRAUD AND ABUSE)	HNFS –STARS and STARSSentinel	24x6. Maintenance window: Sunday 12am PT - 7am PT
HNFS - ZAVANTA	HNFS - Zavanta	24x6. Maintenance window: Sunday 12am PT - 7am PT

The table below identifies the In-Scope Middleware Applications. A Middleware Application is Software that serves as an intermediary between systems software and an application.

Application Middleware	Other Name	Scheduled Uptime (All PT)
HNFS - FEDERAL SERVICE BUS	FSB	24x7. Planned maintenance only with official 24 hour notice to Government.
HNFS - MAPINFO		24x7. Planned maintenance only with official 24 hr notice to Government.

EXHIBIT C-1
PRODUCTION SUPPORT CHARGE

***

EXHIBIT C-2
INDIVIDUAL APPLICATION PRODUCTION SUPPORT CHARGE

***

EXHIBIT C-6
T&M RATES

***

AO Amendment

EXHIBIT C-7

SKILLSET MIX AND SUPPORTING SKILLSET RATES

***

[Represents 4 pages of material pursuant to a request for confidential treatment under Rule 24b-2 of the Securities Exchange Act of 1934 which has been filed separately with the Securities and Exchange Commission]

CDIx697

ASSET PURCHASE AGREEMENT

By and Between

Health Net, Inc., a Delaware corporation

as Seller

and

Cognizant Healthcare Services, LLC,

a Delaware limited liability company

as Buyer

Dated as of November 2, 2014

"*" = CONFIDENTIAL PORTIONS OF THIS DOCUMENT HAVE BEEN OMITTED AND HAVE BEEN SEPARATELY FILED WITH THE SECURITIES AND EXCHANGE COMMISSION PURSUANT TO AN APPLICATION FOR CONFIDENTIAL TREATMENT UNDER RULE 24B-2 UNDER THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED.**

TABLE OF CONTENTS

		Page
ARTICLE I PURCHASE AND SALE		1
1.1	Purchase and Sale of Assets	1
1.2	Assumption of Liabilities	2
1.3	Excluded Assets	2
1.4	***1.5 Conveyance of Acquired Assets	2
1.6	Purchase Price	2
1.7	The Closing	2
1.8	Closing Deliverables	3
1.9	[Reserved]	4
1.10	Closing Conditions	4
1.11	Responsibility for the Closing Conditions	5
1.12	Waiver of Closing Conditions	5
1.13	Termination Prior to Closing	5
1.14	Effect of Termination Prior to Closing	6
ARTICLE II REPRESENTATIONS AND WARRANTIES OF SELLER		6
2.1	Organization and Qualification	6
2.2	Authorization	6
2.3	No Violation	7
2.4	Intellectual Property Rights	7
2.5	Litigation	8
2.6	Brokers' Fees	8
2.7	**DISCLAIMERS**	9
ARTICLE III REPRESENTATIONS AND WARRANTIES OF BUYER		9
3.1	Organization and Qualification	9
3.2	Authorization	9
3.3	No Violation	10
3.4	Financing	10
3.5	Brokers' Fees	10
3.6	No Awareness of a Breach of Seller's Representations and Warranties	10
3.7	Buyer Familiarity with the Acquired Assets	10
ARTICLE IV COVENANTS		10
4.1	Transfer Taxes	10

4.2 Allocation of Purchase Price 10
4.3 Regulatory Communication 11
4.4 Identification of Additional Proprietary Business Rules 11
4.5 Further Assurances 11
4.6 Ordinary Course 12
4.7 Post-Closing Covenants of Buyer and Seller 12
ARTICLE V INDEMNIFICATION 13
5.1 Indemnification by Seller 13
5.2 Indemnification by Buyer 13
5.3 Indemnification Claims 13
5.4 Survival of Representations and Warranties and Indemnities 15
5.5 Waivers of Closing Conditions 15
ARTICLE VI LIMITATIONS OF REMEDIES AND LIABILITY 15
6.1 Acknowledgments of Buyer and Seller 16
6.2 Buyer's Remedies Against Seller 16
6.3 Seller's Remedies Against Buyer 16
ARTICLE VII DEFINITIONS 16
7.1 Defined Terms 16
ARTICLE VIII RULES OF CONSTRUCTION 22
8.1 Entire Agreement 22
8.2 Contracting Parties; No Third Party Beneficiaries 22
8.3 Amendments and Modifications 22
8.4 Governing Law 22
8.5 Consents and Approvals 22
8.6 Waiver 23
8.7 Remedies Cumulative 23
8.8 References 23
8.9 Order of Precedence 23
8.10 Severability 23
8.11 Counterparts 23
8.12 Reading Down 23
ARTICLE IX DISPUTE RESOLUTION 24
9.1 Informal Dispute Resolution 24
9.2 Arbitration 25

9.3 Continued Performance 25
9.4 Equitable Remedies 26
9.5 WAIVER OF JURY TRIAL 26
9.6 Disclaimer of the Uniform Computer Information Transactions Act 26
ARTICLE X GENERAL 26
10.1 Binding Nature and Assignment 27
10.2 Notices 27
10.3 Covenant of Good Faith 27
10.4 Public Disclosures 27
10.5 Expenses 27

EXHIBITS

Exhibit A Assignment of Intellectual Property
Exhibit B List of Initial MSA SOWs

SCHEDULES

Disclosure Schedule
1.1(a) ABS Software
1.1(b) Configurations
1.3 Proprietary Business Rules
*** ***
2.5 Litigation
7.1 Knowledge Individuals of Buyer and Seller

ASSET PURCHASE AGREEMENT

This Asset Purchase Agreement (the "***APA***"), effective as of November 2, 2014 (the "***AP Effective Date***"), is entered into by and between Health Net, Inc., a Delaware corporation with its principal place of business located at 21650 Oxnard Street, Woodland Hills, California 01367 ("***Seller***") and Cognizant Healthcare Services, LLC, a Delaware limited liability company having an office at 500 Frank W. Burr Blvd., Teaneck, New Jersey 07666 ("***Buyer***"). As used in this APA, "***Party***" means either Seller or Buyer, as appropriate, and "***Parties***" means Seller and Buyer.

RECITALS

A. Simultaneously with the execution and delivery of this APA the Parties are entering into an MSA and the Initial SOWs pursuant to which Buyer will provide to Seller certain outsourced business process services via a 'business process-as-a-service' delivery model (collectively, as such services may evolve and be modified over time, the "***BPaaS Services***");

B. Seller owns the Acquired Assets, which it uses together with the Excluded Assets to perform or support many of the functions comprising the BPaaS Services.

C. Seller desires to sell to Buyer, and Buyer desires to purchase from Seller, the Acquired Assets for use in Buyer's business, including providing the BPaaS Services to Seller.

D. The Acquired Assets in the form that will be delivered by Seller to Buyer contain and embody certain Proprietary Business Rules (as defined in ARTICLE VII), which Seller has developed and used for competitive advantage in its business operations, and which Seller intends to continue using for competitive advantage.

E. Although separately defined, the Acquired Assets and the Proprietary Business Rules are commingled such that it is not practical to produce a version of the Acquired Assets that does not, to some degree, include portions of the Proprietary Business Rules. Nevertheless, the Parties have agreed that specified information contained within the Proprietary Business Rules may not be disclosed, or used by Buyer (or its agents) to provide services to any customer other than Seller and Seller's Affiliates.

F. Certain capitalized terms used in this APA are defined in the place where they are used. Others are defined in Section 7.1.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

ARTICLE I

PURCHASE AND SALE

1.1 **Purchase and Sale of Assets.** Upon the terms and subject to the conditions of this APA, including the satisfaction or waiver of the conditions set forth in this APA, Seller shall sell, transfer, convey, assign and deliver to Buyer, free and clear of any Security Interest, and Buyer shall purchase from Seller, at the Closing and as of the Closing Date, all of the right, title and interest of Seller in the following assets and properties of Seller (collectively, the "***Acquired Assets***"):

(a) the ABS Software set forth on Schedule 1.1(a) (collectively, the "***ABS Platform***")***;

(b) the Configurations set forth on Schedule 1.1(b); and

(c) all Intellectual Property Rights owned by Seller covering, incorporated in, underlying or otherwise appurtenant to the ABS Platform and the Configurations (collectively, the "***Acquired Seller Intellectual Property Rights***").

1.2 **Assumption of Liabilities.** Notwithstanding any other provision of this APA to the contrary, Buyer shall not assume or become responsible for any liabilities of Seller, and Seller shall remain liable for any and all Retained Liabilities.

1.3 **Excluded Assets.** Notwithstanding anything to the contrary in this APA, the Parties expressly acknowledge and agree that Seller is not selling, conveying, transferring, assigning or delivering to Buyer any right, title or interest in, to or under any other assets, properties or rights, whether tangible or intangible, real, personal or mixed, of Seller not expressly included in the definition of Acquired Assets (collectively, the "***Excluded Assets***"). Schedule 1.3 sets forth descriptions of various components of the Acquired Assets that contain data and information specific to Seller, its providers, and customers contained within the components of the ABS Platform, including the content of actuarial tables and plan tables, and employer benefit configurations contained within the capitation and configuration modules of the Acquired Assets, and related Seller Data and Seller Confidential Information (collectively, "***Proprietary Business Rules***"). Notwithstanding the physical incorporation or inclusion of the Proprietary Business Rules in or with the Acquired Assets delivered to Purchaser by Seller, the Proprietary Business Rules are Excluded Assets, as are all Seller trademarks.

1.4 ***__**Conveyance of Acquired Assets.**__ The Acquired Assets shall be sold, conveyed, transferred, assigned and delivered pursuant to transfer agreements and such other instruments in such form as may be necessary or appropriate to effect a conveyance of the Acquired Assets in the jurisdictions in which such transfers are to be made. Such transfer agreements shall be prepared by Seller and shall include: (i) a bill of sale in substantially the form attached hereto as Exhibit A (the "***Bill of Sale***"), (ii) a copyright assignment agreement in substantially the form attached hereto as Exhibit B (the "***Copyright Assignment Agreement***"), (iii) an assignment agreement for the other Acquired Seller Intellectual Property Rights in substantially the form attached hereto as Exhibit C (the "***Intellectual Property Rights Assignment Agreement***" and, together with the Bill of Sale and the Copyright Assignment Agreement, the "***Ancillary Agreements***"), and (iv) such other agreements and instruments as may be required to effect the purchase and conveyance of the Acquired Assets and shall be executed at or no later than the Closing by Seller and Buyer.

1.5 **Purchase Price.** The cash consideration to be paid by Buyer to Seller as consideration for the Acquired Assets shall be the sum of Fifty Million U.S. Dollars (US$ *** (the "***Purchase Price***").

1.6 **The Closing.** Except as otherwise provided herein, the consummation of the transactions contemplated by this APA (the "***Closing***") shall take place at the offices of Pillsbury Winthrop Shaw Pittman LLP in Los Angeles, California, simultaneously with the transfer of the Transferred Employees of Seller to Buyer pursuant to the MSA, on the BPaaS Services Commencement Date (the "***Closing Date***"). Unless otherwise expressly provided herein, all acts and

proceedings to be taken and all documents to be executed and delivered by the Parties at the Closing shall be deemed to have been taken and executed and delivered simultaneously, and except as permitted hereunder, no acts or proceedings shall be deemed taken nor any documents executed or delivered until all such acts and proceedings have been taken and all such documents have been executed and delivered. Notwithstanding anything to the contrary in this APA, the Closing will be deemed effective as of 11:59 p.m. Pacific Time on the Closing Date (the "***Effective Time***").

1.7 **Closing Deliverables.**

(a) Buyer Deliverables. At (or prior to) the Closing, Buyer shall deliver:

(i) the Purchase Price in full by wire transfer of immediately available funds in U.S. dollars to an account or accounts designated by Seller in writing to Buyer at least three (3) Business Days prior to the Closing Date;

(ii) to Seller, a duly executed counterpart of the MSA, the Initial SOWs and the Ancillary Agreements to which Buyer is a party; and

(iii) to Seller, a certificate signed by an authorized officer of Buyer, dated as of the Closing Date and certifying that correct and complete copies of the resolutions of Buyer's board of directors approving this APA, the MSA, the Initial SOWs and the Ancillary Agreements to which it is a party and authorizing the execution hereof and thereof and the consummation of the transactions contemplated hereby and thereby are attached thereto.

(b) Seller Deliverables. At (or prior to) the Closing, Seller shall deliver to Buyer:

(i) a duly executed counterpart of the MSA, the Initial SOWs and the Ancillary Agreements;

(ii) a current version of the ABS Platform (which shall include or be accompanied by a copy of or means for Buyer to access all Seller Data that is needed and used, at the Closing Date, to operate the ABS Platform), in machine readable object code form, together with a current version of the ABS Platform source code, it being understood and agreed that Seller will not be required to locate and delete all retained copies and versions of the ABS Platform object code and source code, but such copies shall be Buyer 's Confidential Information from and after the Closing, shall be subject to Buyer's rights therein, and shall not be used by Seller in a live production environment;

(iii) a current version of the Configurations, in electronic form;

(iv) written evidence of the release of all Security Interests and any other liens or encumbrances affecting and/or relating to the Acquired Assets, to the reasonable satisfaction of Buyer, effective prior to or simultaneously with the Closing; and

(v) a certificate signed by the secretary of Seller, dated as of the Closing Date and certifying that correct and complete copies of the resolutions of Seller's board of directors approving this APA, the MSA, the Initial SOWs and the Ancillary Agreements authorizing the execution hereof and thereof and the consummation of the transactions contemplated hereby and thereby are attached thereto.

At Buyer's option, communicated in writing to Seller at least twenty (20) Business Days prior to the Closing Date, Seller will deliver the ABS Platform and Configurations to Buyer via remote telecommunications or the 'load and leave' method to Buyer's data center facility located in Chandler, Arizona.

1.8 **[Reserved]**

1.9 **Closing Conditions.** The sale and purchase of the Acquired Assets pursuant to this APA are in all respects conditional upon the occurrence and satisfaction of the following conditions (each, a "***Closing Condition***" and, collectively, the "***Closing Conditions***") on or before the BPaaS Services Commencement Date:

(a) Seller shall have received unconditional consent, approval and/or clearance of the transactions contemplated by this APA and the MSA by each of Seller's regulators whose approval is required;

(b) the transition of employees from Seller to Buyer contemplated by Schedule E (*Employee Transfer*) of the MSA shall have occurred;

(c) the MSA and the Initial SOWs shall have been duly executed and delivered by Seller;

(d) the representations and warranties of Seller (including the Fundamental Representations) shall be true and correct in all material respects as of the Closing Date with the same effect as though made on and as of the Closing Date;

(e) Seller shall have complied in all material respects with the covenants and provisions hereof required to be performed or complied with by Seller between the AP Effective Date and the Closing Date;

(f) Since the AP Effective Date, no Seller Material Adverse Effect shall have occurred;

(g) Seller shall have delivered to Buyer the Seller Deliverables set forth in Section 1.8(b);

(h) the MSA and the Initial SOWs shall have been duly executed and delivered by Buyer;

(i) the Fundamental Representations of Buyer shall be true and correct in all material respects at and as of the Closing Date with the same effect as though made on and as of the Closing Date;

(j) the representations and warranties of Buyer (other than the Fundamental Representations) shall be true and correct as of the Closing Date with the same effect as though made on and as of the Closing Date, except for any failure to be true and correct that would not reasonably be expected to have a Buyer Material Adverse Effect;

(k) Buyer shall have complied in all material respects with the covenants and provisions hereof required to be performed or complied with by Buyer between the AP Effective Date and the Closing Date;

(l) Since the AP Effective Date, no Buyer Material Adverse Effect shall have occurred;

(m) Buyer shall have delivered to Seller the Buyer Deliverables set forth in Section 1.8(a); and

(n) Since the AP Effective Date, no preliminary or permanent injunction or other order of any court of competent jurisdiction restraining or prohibiting the consummation of the transactions contemplated by this APA or the MSA shall be in effect, nor shall any suit have been filed and pending seeking such a preliminary or permanent injunction, nor shall any Law have gone into effect that makes the consummation of the transactions contemplated by this APA or the MSA illegal or otherwise prohibited.

1.10 **Responsibility for the Closing Conditions.** Seller shall be responsible for the Closing Conditions set forth in Sections 1.10(a) to 1.10(g), inclusive, and Section 1.10(n), and Buyer shall be responsible for the Closing Conditions set forth in Sections 1.10(h) to 1.10(n), inclusive. Seller and Buyer are both responsible for the Closing Condition set forth in Section 1.10(b). Each Party agrees to act in good faith and to use commercially reasonable efforts to cause each of the Closing Conditions for which it is responsible to occur and be satisfied as soon as reasonably possible, but at the latest by the BPaaS Services Commencement Date. The Parties shall keep each other informed on the progress and status of the satisfaction of the Closing Conditions and, for such purpose, each Party shall notify the other Party promptly in writing of the satisfaction of a Closing Condition for which it is responsible hereunder and shall present to the other Party documents evidencing, to the reasonable satisfaction of the other Party, the satisfaction of the Closing Condition.

1.11 **Waiver of Closing Conditions.** Seller may in its sole discretion and upon such terms as it thinks fit waive in writing the fulfillment by Buyer of the Closing Conditions set forth in Sections 1.10(h) to 1.10(n), inclusive, and Section 1.10(b). Buyer may in its sole discretion and upon such terms as it thinks fit waive in writing the fulfillment by Seller of the Closing Conditions set forth in Sections 1.10(a) to 1.10(g), inclusive.

1.12 **Termination Prior to Closing.** This Agreement may be terminated (which termination shall be in addition to and without prejudice to any other rights and remedies available, including the right to claim damages, except as otherwise provided herein) by the terminating Party giving written notice of termination to the other Party at any time prior to the Closing, as follows:

(a) notwithstanding any other provision of this Agreement to the contrary, by Seller in connection with Seller exercising its right to terminate the MSA under Section 16.1(n) of the MSA, in which event Seller's payment of the Breakup Fee to Buyer shall be Buyer's sole and exclusive remedy in respect of Seller's termination of this Agreement;

(b) by Seller, if the Closing Conditions pursuant to Sections 1.10(h) to 1.10(n), inclusive, and Section 1.10(b) have not been fulfilled by Buyer (or have become incapable of fulfillment as a result of events beyond the control of Seller) or waived by Seller pursuant to Section 1.12 on or before the BPaaS Services Commencement Date; and

(c) by Buyer, if the Closing Conditions pursuant to Sections 1.10a) to 1.10(g), inclusive, and Section 1.10(n) have not been fulfilled by Seller (or become incapable of fulfillment as a result of events beyond the control of Buyer) and have not been waived by Buyer pursuant to Section 1.12 on or before the BPaaS Services Commencement Date;

provided, however, that the right to terminate this APA pursuant to Section 1.13(b) and Section 1.13(c) shall not be available to any Party whose failure to fulfill or comply with any obligations pursuant to this APA shall have been the cause of, or shall have resulted in, the failure of a Closing Condition or of the Closing to occur or be satisfied prior to such date.

1.13 **Effect of Termination Prior to Closing.** Upon termination of this APA in accordance with Section 1.13, the rights and obligations under this APA shall terminate automatically, save for any rights and obligations accrued because of a prior breach of this APA and the rights and obligations set forth in Sections 1.13(a), 1.14, 8.4, 8.6 to 8.9, inclusive, ARTICLE IX, and Sections 10.2 to 10.4, inclusive, which shall survive termination of this APA.

ARTICLE II

REPRESENTATIONS AND WARRANTIES OF SELLER

Seller hereby represents and warrants to Buyer as set forth in Sections 2.1 to 2.6, inclusive, as of the AP Effective Date and the Closing Date, subject to Section 2.7 and except as otherwise disclosed in the Disclosure Schedule.

2.1 **Organization and Qualification.** Seller is a corporation duly organized, validly existing and in good standing under the Laws of the State of Delaware. Seller is duly licensed or qualified to conduct its business and, if applicable, is in good standing under the Laws of each jurisdiction (other than the jurisdiction of its organization) in which the conduct of its business or the ownership of its properties or assets requires such license or qualification, except where the failure to be so qualified or licensed and in good standing would not reasonably be expected to have, in the aggregate, a Seller Material Adverse Effect. Seller has all requisite corporate power and authority to carry on the business in which it is engaged and to own and use the assets and properties owned and used by it, including the Acquired Assets.

2.2 **Authorization.** Seller has all requisite power and authority to execute and deliver this APA, the MSA, the Initial SOWs and the Ancillary Agreements and to perform its obligations hereunder and thereunder. The execution, delivery and performance by Seller of this APA, the MSA, the Initial SOWs and the Ancillary Agreements, and the consummation by Seller of the transactions contemplated hereby and thereby, have been duly and validly authorized by all necessary corporate action on the part of Seller; provided, however, that Seller has advised Buyer that the execution, delivery and performance by Seller of this APA, the MSA, the Initial SOWs and the Ancillary Agreements, and the consummation by Seller of the transactions contemplated hereby and thereby are subject to Seller receiving any approvals required from Seller's regulators. This APA has been duly and validly executed and delivered by Seller and, assuming due execution by Buyer, constitutes, and each of the MSA, the Initial SOWs and the Ancillary Agreements, upon its execution and delivery by Seller, assuming due execution by Buyer, will constitute, a valid and binding obligation of Seller, enforceable against Seller in accordance with its terms, except as may be limited by (a) applicable bankruptcy, insolvency, reorganization, moratorium or other similar Laws of general application

relating to or affecting the enforcement of creditor rights, (b) limitations of public policy, and (c) the availability of specific performance or other equitable remedies.

2.3 **No Violation.** Neither the execution and delivery by Seller of this APA, the MSA, the Initial SOWs or the Ancillary Agreements, nor the consummation by Seller of the transactions contemplated hereby or thereby to be performed by Seller, will (a) conflict with or violate any provision of Seller's Corporate Documents; (b) conflict with, result in a breach of, constitute (with or without due notice or lapse of time or both) a default under, any material contract or instrument to which Seller is a party or by which Seller is bound which could reasonably be expected to result in the imposition of any Security Interest upon any of the Acquired Assets or impair Seller's ability to sell and convey the Acquired Assets to Buyer as contemplated hereby; or (c) violate any Law applicable to Seller or any of the Acquired Assets; except such as would not prevent or delay in any material respect the consummation of the transactions contemplated hereby.

2.4 **Intellectual Property Rights**.

(a) Registered Intellectual Property Rights in Respect of the Acquired Assets. Seller has not made any copyright or patent filings or applications with respect to the Acquired Assets and, to Seller's Knowledge, no Person other than Seller has obtained or applied for any patents or registered copyrights in or with respect to any of the Acquired Assets.

(b) ***

(c) ***

(d) Ownership; Use and Exploitation Rights. Other than the Third Party Materials, ***Seller (i) is the sole and exclusive owner of the entire right, title and interest in and to the Acquired Assets, and (ii) no third Person has any right, title or interest in or to the Acquired Assets, in whole or in part. Other than the Third Party Materials, and subject to Section 4.7, (i) there are no restrictions on the ability of Seller (or any successor or assign thereof) to Use or otherwise exploit the Acquired Assets ***.

(e) Transferability. Seller has the power and right to transfer, sell, assign, convey and deliver the Acquired Assets to Buyer in accordance with the terms of this APA. Upon execution and delivery by Seller to Buyer of the instruments of conveyance referred to in Section 1.5, Buyer will become the true and lawful owner of, and will receive good title to, the Acquired Assets *** , free of any Security Interests. Upon execution and delivery by Seller to Buyer of the instruments of conveyance referred to in Section 1.5, the Acquired Assets (other than the Third Party Materials) will be owned by Buyer immediately following the Closing . ***

(f) Infringement.

(i) There are no pending claims, and to Seller's Knowledge after due inquiry by Seller's Knowledge Individuals, there are no threatened claims (or basis for a claim) that any of the Acquired Assets, or the Use or practice thereof by Seller, infringes any third Person's Intellectual Property Rights that arise or are enforceable under the laws of the U.S.

(ii) Seller has the sole and exclusive right to bring actions for infringement or unauthorized Use of the Acquired Assets (other than the Third Party Materials) up to the Effective

Time. To the Knowledge of Seller, there is no infringement or unauthorized Use by a third Person that could reasonably be the basis for any such action.

(g) Protection.

(i) Seller has taken reasonable measures to protect the proprietary nature of each item of the Acquired Seller Intellectual Property Rights and to maintain, and to ensure that any entity or company to whom Seller has disclosed, or provided possession of or access to any item of Acquired Seller Intellectual Property Rights that constitutes a trade secret or confidential information maintains, the Acquired Seller Intellectual Property Rights in confidence.

(ii) Except as set forth in Section 2.4(g)(ii) of the Disclosure Schedule, Seller has not disclosed or delivered the source code for the ABS Platform, or permitted it to be disclosed or delivered, to any Person other than (A) those employees and contractors of Seller who had a need to know such source code and who have executed confidentiality agreements on no less than commercially reasonable terms, and (B) Seller's customers pursuant to license agreements (including those listed on Section 2.4(g)(ii) of the Disclosure Schedule) entered into in the Ordinary Course of Business, and Seller has taken reasonable measures to prevent further disclosure, as the case may be, of such source code.

(iii) Seller has not (A) licensed or otherwise authorized any third Person reseller or original equipment manufacturer (OEM) to make, have made, use or sell, copy, distribute, modify, reverse engineer, decompile, prepare derivatives of, or make available, any Acquired Assets, or (B) conveyed, disclosed or licensed to any third Person any trade secret included in the Acquired Assets (as "trade secret" is defined in the Uniform Trade Secrets Act) under circumstances that could reasonably be expected to cause a Buyer Material Adverse Effect.

(iv) Seller has not incurred any Security Interests on the Acquired Assets, or permitted or allowed any of the Acquired Assets to be subject to any Security Interests other than Routine Liens.

(h) Material Defects. Seller uses commercially reasonable efforts and employs commercially available tools in a responsible manner to protect the Acquired Assets from the potentially harmful effects of any back door, time bomb, Trojan horse, worm, drop-dead device, virus (as these terms are commonly used in the computer software industry), or other software routines or hardware components designed to permit unauthorized access, to disable or erase software, hardware or data, or to perform any other similar type of functions.

2.5 **Litigation.** Except as set forth on Section 2.5 of the Disclosure Schedule, there is no Legal Proceeding pending or, to the Knowledge of Seller, threatened against Seller (or any Person for whose acts or omissions Seller may be vicariously liable) in connection with or related to the Acquired Assets. There are no judgments, orders or decrees outstanding against Seller in connection with or related to the Acquired Assets. Seller has not received any notice or communication from any Governmental Entity alleging that the Acquired Assets violate or do not comply in any material respect with any Law.

2.6 **Brokers' Fees.** Seller does not have any liability or obligation to pay any fees or commissions to any broker, finder or agent with respect to the transactions contemplated by this APA.

2.7 **DISCLAIMERS.** BUYER ACKNOWLEDGES AND AGREES THAT SELLER'S REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS APA ARE SUBJECT TO THE FOLLOWING DISCLAIMERS:

(a) BUYER, AS SELLER'S CONTRACTOR, HAS MADE SUBSTANTIAL MODIFICATIONS TO THE ABS PLATFORM AND CONFIGURATIONS OVER THE YEARS, AND SELLER MAKES NO REPRESENTATIONS AND WARRANTIES WITH RESPECT TO ANY MODIFICATIONS OR ADDITIONS TO THE ABS PLATFORM AND/OR CONFIGURATIONS MADE BY OR ON BEHALF OF BUYER, OR WITH RESPECT TO ANY THIRD PARTY MATERIALS.

(b) THE USE AND OPERATION OF THE ABS PLATFORM IS DEPENDENT ON A NUMBER OF SOFTWARE PRODUCTS AND PROGRAMS OWNED BY THIRD PERSONS, INCLUDING THIRD PARTY MATERIALS, WHICH SELLER DOES NOT OWN AND THE LICENSES FOR WHICH SELLER IS NOT CONVEYING TO BUYER.

(c) SELLER MAKES NO REPRESENTATIONS AND PROVIDES NO WARRANTIES TO BUYER OTHER THAN THE EXPRESS REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS ARTICLE II. SELLER EXPRESSLY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE IN RELATION TO THE ACQUIRED ASSETS.

ARTICLE III

REPRESENTATIONS AND WARRANTIES OF BUYER

Buyer hereby represents and warrants to Seller as set forth in Sections 3.1 to 3.5, inclusive, as of the AP Effective Date and the Closing Date.

3.1 **Organization and Qualification.** Buyer is a limited liability company duly organized, validly existing and in good standing under the Laws of the State of Delaware. Buyer is, to the Knowledge of Buyer, duly licensed or qualified to conduct its business and, if applicable, is in good standing under the Laws of each jurisdiction (other than the jurisdiction of its organization) in which the conduct of its business or the ownership of its properties or assets requires such license or qualification, except where the failure to be so qualified or licensed and in good standing would not reasonably be expected to have, in the aggregate, a Buyer Material Adverse Effect. Buyer has all requisite power and authority as a limited liability company to carry on the business in which it is engaged and to own and use the assets and properties owned and used by it.

3.2 **Authorization.** Buyer has all requisite power and authority to execute and deliver this APA, the MSA, the Initial SOWs and the Ancillary Agreements to which it is a party and to perform its obligations hereunder and thereunder. The execution, delivery and performance by Buyer of this APA, the MSA, the Initial SOWs and the Ancillary Agreements to which it is a party, and the consummation by Buyer of the transactions contemplated hereby and thereby, have been duly and validly authorized by all necessary corporate action on the part of Buyer. This APA has been duly and validly executed and delivered by Buyer and, assuming due execution by Seller, constitutes, and each of the MSA, the Initial SOWs and the Ancillary Agreements, upon its execution and delivery by Buyer, assuming due execution by Seller, will constitute, a valid and binding obligation of Buyer,

enforceable against Buyer in accordance with its terms, except as may be limited by (a) applicable bankruptcy, insolvency, reorganization, moratorium or other similar Laws of general application relating to or affecting the enforcement of creditor rights, (b) limitations of public policy, and (c) the availability of specific performance or other equitable remedies.

3.3 **No Violation.** Neither the execution and delivery by Buyer of this APA, the MSA, the Initial SOWs or the Ancillary Agreements, nor the consummation by Buyer of the transactions contemplated hereby or thereby to be performed by Buyer, will (a) conflict with or violate any provision of Buyer's Corporate Documents; (b) require on the part of Buyer any notice to or filing with, or any permit, authorization, consent or approval of, any Governmental Entity; (c) conflict with, result in a breach of, constitute (with or without due notice or lapse of time or both) a default under, any material contract or instrument to which Buyer is a party or by which Buyer is bound which could reasonably be expected to impair Buyer's ability to purchase and acquire the Acquired Assets from Seller as contemplated hereby or to otherwise consummate the transactions contemplated hereby; or (d) violate any Law applicable to Buyer or any of its assets or properties; except such as would not prevent or delay in any material respect the consummation of the transactions contemplated hereby.

3.4 **Financing.** Buyer has sufficient assets and capital to pay the Purchase Price and to consummate all of its obligations and the transactions contemplated by this APA, the MSA, the Initial SOWs and the Ancillary Agreements to which it is a party.

3.5 **Brokers' Fees.** Buyer has no liability or obligation to pay any fees or commissions to any broker, finder or agent with respect to the transactions contemplated by this APA.

3.6 **No Awareness of a Breach of Seller's Representations and Warranties.** Buyer's Knowledge Individuals are not aware of any basis to believe that any of Seller's representations and warranties is inaccurate or untrue, nor are they aware of the existence of any third party claim (or basis for a claim) that the ABS Platform infringes any third Person's Intellectual Property Rights that arise or are enforceable under the laws of the U.S.

3.7 **Buyer Familiarity with the Acquired Assets.** Buyer, in its role as a contractor to Seller for a number of years, is familiar with and has substantial knowledge concerning the Acquired Assets and has been afforded a reasonable opportunity to examine, review, and test them, and thereby assess their functional capabilities and suitability for the purposes for which Buyer intends to use them.

ARTICLE IV

COVENANTS

4.1 **Transfer Taxes.** All transfer, filing, recordation (including the cost of recording the assignment or transfer of Intellectual Property Rights), ad valorem, value added, bulk sales, stamp duties, excise, license or similar fees or Taxes (collectively, "***Transfer Taxes***") shall be borne by Buyer. Buyer shall pay to Seller the amount of any Transfer Taxes which Seller or any of its Affiliates is required to collect and remit to a taxing authority no later than five (5) days prior to the date such Transfer Taxes are due. Seller and Buyer shall cooperate with each other in the provision of any information or preparation of any documentation that may be necessary or useful for obtaining any available mitigation, reduction or exemption from any Transfer Taxes.

4.2 **Allocation of Purchase Price.** As promptly as possible, but in any event within one hundred twenty (120) calendar days after the Closing Date, with respect to the Acquired Assets, Seller

shall propose to Buyer an allocation of the Purchase Price among the Acquired Assets. Buyer shall have sixty (60) calendar days to review the allocation proposed by Seller. If Buyer does not, within such sixty (60) calendar-day period, deliver written comments to the allocation proposed by Seller, the allocation will be binding upon Buyer and its Affiliates. Seller shall make such changes to the allocation as are reasonably requested by Buyer, and such final allocation (the "***Final Allocation***"), shall be conclusive and final for all purposes. Each Party and its respective Affiliates, as applicable, shall (i) be bound, to the extent permitted by applicable Law, by the allocations determined pursuant to this Section 4.2 for purposes of determining any Taxes, (ii) prepare and file all Tax returns in a manner consistent with the Final Allocation, unless prevented from doing so under any applicable rule or pursuant to a determination within the meaning of Section 1313 of the Code (or similar provision of applicable Law), and (iii) not take any position inconsistent with the Final Allocation in any Tax return, Tax proceeding or otherwise; provided that, in the event that the Final Allocation is disputed by any Governmental Entity, the Party receiving notice of such dispute shall promptly notify and consult with the other Party concerning the resolution of such dispute, and the other Party shall cooperate with the Party giving the notice in an effort to resolve the dispute.

4.3 **Regulatory Communication**. Seller will endeavor in good faith to obtain required regulatory approvals of this Agreement and the transactions contemplated by this Agreement, the MSA, and the Initial SOWs. Seller will keep Buyer informed on a reasonably current basis of progress in obtaining the regulatory approvals set forth on Schedule 1.10(a) and will provide Buyer with such information as Buyer shall reasonably request. Regularly and at Buyer's reasonable request, Seller will meet and discuss progress toward obtaining such approvals. Seller will notify Buyer of any regulatory filing or information request, prior to filing or disclosure, in which any Confidential Information of Buyer (including this APA or the terms hereof) may be disclosed and provide draft and final copies thereof to Buyer. In the event that any Confidential Information of Buyer or the terms of this APA will be disclosed, Seller and Buyer will cooperate to redact to a reasonable extent the information contained in such filings and Seller will request and use reasonable efforts to obtain confidential treatment of such information, if requested by Buyer.

4.4 **Identification of Additional Proprietary Business Rules.** Each Party agrees to cooperate fully with the other and to use its reasonable best efforts to further identify and further define, within 90 days after the AP Effective Date, the Proprietary Business Rules and other Seller Data and Seller Confidential Information contained in the Acquired Assets and to update Schedule 4.4 accordingly. Each Party will promptly provide to the other Party any information or documents useful in identifying and locating any of such material in the Acquired Assets and reasonably requested by the other Party. Each Party will promptly disclose to the other Party any of such material identified by it or its Affiliates in the Acquired Assets.

4.5 **Further Assurances.** Each Party agrees to cooperate fully with the other and to use its reasonable best efforts to evidence and perfect the assignment and transfer of the Acquired Assets to Buyer and secure recorded ownership of the Acquired Assets by Buyer. At any time and from time to time after the Closing, at the request of Buyer and without further consideration, Seller shall execute and deliver such other instruments of sale, transfer, conveyance and assignment and take such actions as Buyer may reasonably request to more effectively transfer, convey and assign to Buyer, and to confirm Buyer's rights to, title in, and ownership of, the Acquired Assets and to place Buyer in actual possession and operating control thereof. Prior to and after the Closing, Buyer and Seller shall cooperate in good faith and make reasonable efforts to identify and transfer to Buyer any Software or other rights or assets that constitute part of the Acquired Assets but were not transferred and delivered at Closing.

4.6 **<u>Ordinary Course</u>.** From and after the date hereof until the earlier of the Closing or the termination of this Agreement in accordance with its terms, Seller shall, except as consented to in writing by Buyer (which consent shall not be unreasonably withheld or delayed): (a) operate and maintain the Acquired Assets in all material respects in the Ordinary Course of Business; (b) not take any action that would cause a Seller Material Adverse Effect or omit to take any action reasonably necessary to prevent a Seller Material Adverse Effect; (c) not sell, license, lease, transfer, or otherwise dispose of any of the Acquired Assets; (d) not materially modify or terminate prior to the expiration of its term any agreement relating to the Acquired Assets; and (e) not commit (orally or in writing) to any of the foregoing described in clauses (b) through (d).

4.7 **<u>Post-Closing Covenants of Buyer and Seller</u>.**

(a) Prior to using the Acquired Assets to provide services to any customer other than Seller and Seller's Affiliates, Buyer shall produce and deliver to Seller for Seller's review and approval a version of the ABS Platform and the Configurations for Buyer's commercial use (the "***Commercial ABS Version***"). Buyer may deliver the Commercial ABS Version in its entirety or, from time to time, in segments at Buyer's option. Seller's approval shall not be unreasonably delayed, conditioned or withheld.

(b) Seller shall use commercially reasonable efforts (including engaging third Persons to assist in the review if reasonably necessary, provided such third Person is not a competitor to the Buyer as listed in Schedule M of the MSA) to review the delivered Commercial ABS Version or the segment thereof (in either case, the "***Submitted Material***") within [60] days after receiving the Submitted Material from Buyer (the "***Review Period***"). Seller's review shall be limited to reviewing the Submitted Material for the purpose of confirming that the Proprietary Business Rules and all other Seller Data and Seller Confidential Information have been removed (or otherwise rendered inaccessible and unusable for third parties) from the Commercial ABS Version or the portions thereof that have been included in the Submitted Material (the "***Sanitization Confirmation***"). Within the Review Period, Seller shall provide a Sanitization Confirmation with respect to the Submitted Materials or provide specific reasons as to why and/or how the Submitted Materials have failed to be sanitized to Seller's reasonable satisfaction. If Seller does not furnish a written notice to Buyer specifying how and to what extent the Submitted Material still contain usable unmasked Proprietary Business Rules and/or Seller Data and/or Seller Confidential Information prior to the end of the Review Period, then Seller will be deemed to have provided a Sanitization Confirmation with respect to the Submitted Materials.

(c) Buyer acknowledges and agrees that Buyer does not have the right to, and that Buyer shall not, use or disclose any of the Proprietary Business Rules or any other Seller Confidential Information for any purpose other than to perform the BPaaS Services and other services for Seller and Seller's Affiliates. Seller acknowledges and agrees that after the approval or deemed approval of Submitted Material, Buyer shall have free right to use and otherwise exploit for commercial purposes any and all aspects of the Submitted Material and to the extent required for such use the Seller hereby grants Buyer a perpetual, royalty-free license to Use such information and material in the Commercial ABS Version (and any future versions or modifications thereto) in the service of other customers of Buyer or its Affiliates.

ARTICLE V

INDEMNIFICATION

5.1 **Indemnification by Seller.** ***

5.2 **Indemnification by Buyer.** ***

5.3 **Indemnification Claims.** The following procedures will apply to Third Party Actions for which a Party seeks to be indemnified pursuant to this Agreement ("***Indemnity Claims***"):

(a) Notice. Promptly after an indemnitee receives notice of any Indemnity Claim for which it will seek indemnification pursuant to this Agreement, the indemnitee will notify the indemnitor of the Indemnity Claim in writing (an "***Indemnity Notice***"). No failure to so notify the indemnitor will abrogate or diminish the indemnitor's obligations under this Section 5.3 if the indemnitor has or receives knowledge of the Indemnity Claim by other means, or if the failure to notify does not materially prejudice its ability to defend the Indemnity Claim, or if the indemnitor does not have the right to defend the Indemnity Claim pursuant to Section 5.3(c). Within fifteen (15) days after receiving an indemnitee's Indemnity Notice of an Indemnity Claim, or otherwise obtaining knowledge of the Indemnity Claim, but no later than ten (10) days before the date on which any formal response to the Indemnity Claim is due, the indemnitor will notify the indemnitee in writing (a "***Notice of Election***") as to whether:

(i) the indemnitor acknowledges its obligation to indemnify and hold the indemnitee harmless with respect to such Indemnity Claim, and

(ii) with respect to any such Indemnity Claim that is not an Identified Seller Indemnity Claim (as defined below), the indemnitor elects to assume control of the defense and settlement of the Indemnity Claim.

Each Notice of Election shall be delivered to the indemnitee at the address set forth in Section 27.5 (Notices), as such address may be modified pursuant to such Section.

(b) Procedure Following Indemnity Notice for Indemnity Claims that are not Identified Seller Indemnity Claims. With respect to any Indemnity Claim that is not an Identified Seller Indemnity Claim, if the indemnitor timely (*i.e.*, in accordance with Section 5.3(a)) delivers a Notice of Election that both (1) acknowledges indemnitor's obligation to indemnify and hold the indemnitee harmless with respect to such Indemnity Claim, and (2) includes an express election to assume control of the defense and settlement of such Indemnity Claim, then:

(i) the indemnitor will be entitled to have sole control over the defense and settlement of such Indemnity Claim; provided that the indemnitee shall have the right to approve both the legal counsel selected by the indemnitor and, in the indemnitee's sole discretion, any settlement (or portion thereof) that is not a monetary settlement, including settlements involving injunctive relief; and

(ii) the indemnitor will not be required to reimburse the indemnitee for (1) any legal expenses incurred by the indemnitee in defending or settling such Indemnity Claim after the indemnitee's receipt of such Notice of Election unless reasonable and necessary (e.g., costs incurred prior to receipt of the Indemnitor's Notice of Election), or (2) any amounts paid or payable by the

indemnitee in settlement of such Indemnity Claim after the indemnitee's receipt of such Notice of Election if the settlement was agreed to without the written consent of the indemnitor.

(c) Procedure for Identified Seller Indemnity Claims. An "***Identified Seller Indemnity Claim***" means any of the following Indemnity Claims brought against Seller with respect to which Seller expressly elects to retain control of the defense and settlement in its written Indemnity Notice to Buyer pursuant to Section 5.3(a) (or as soon as reasonably practicable thereafter so long as such notice is given by Seller prior to receipt of Buyer's Notice of Election pursuant to Section 5.3(a)), and for which Seller indicates in such Indemnity Notice that Seller will seek indemnification from Buyer pursuant to this Agreement:

(i) any Indemnity Claim brought by a governmental or regulatory entity (a "***Public Indemnity Claim***"); and

(ii) any Indemnity Claim brought by a private party that is based on the same events that also resulted in a Public Indemnity Claim being brought against Seller, and where adjudication of the private party Indemnity Claim or some part of it may result in collateral estoppel with respect to a material issue of the Public Indemnity Claim.

With respect to any Identified Seller Indemnity Claim, if Buyer timely (i.e., in accordance with Section 5.3(a)) delivers a Notice of Election acknowledging its obligation to indemnify and hold Seller harmless with respect to such Identified Seller Indemnity Claim, then:

(iii) Seller will be entitled to have sole control over the defense and settlement of such Identified Seller Indemnity Claim at the cost and expense of Buyer, including payment of any settlement, judgment or award and the reasonable costs of defending or settling such Identified Seller Indemnity Claim; provided that in the event of a settlement by Seller, Buyer shall only be obligated to reimburse Seller for reasonable amounts paid or payable by Seller in settlement of such Identified Seller Indemnity Claim (the reasonableness of such amount determined by taking into consideration all of the facts and circumstances relating to such Identified Seller Indemnity Claim, including reputational risks to Seller, the potential for the Identified Seller Indemnity Claim to cause adverse impacts to Seller's business or operations, and costs incurred by Seller as a result of or in connection with such Identified Seller Indemnity Claim); and

(iv) Seller shall keep Buyer informed regarding the status of and developments in any such Identified Seller Indemnity Claim (subject to execution where appropriate of a mutually acceptable joint defense or common interest agreement), shall invite and allow Buyer to be present at relevant discussions, negotiations and proceedings to the greatest extent practicable, and shall, in advance of settling any such Identified Seller Indemnity Claim, meet and confer with Buyer regarding the terms and conditions of such settlement with respect to which it intends to seek indemnification so as to give Buyer an opportunity to provide its input regarding such terms and conditions; and

(v) in the event that Seller rejects any settlement offer with respect to an Identified Seller Indemnity Claim *** then Buyer will be responsible only for reimbursing Seller ***(b) the reasonable amounts paid or payable by Seller in settlement of such Identified Seller Indemnity Claim, considering the factors described in Section 5.3(c)(iii) above; and

(vi) subject to the limitations described in Sections 5.3(c)(iii) and 5.3(c)(v) above, Buyer will promptly reimburse Seller upon demand for all Losses suffered or incurred by Seller as a result of or in connection with such Identified Seller Indemnity Claim.

(d) Procedure Where No Proper Notice of Election Is Delivered (Applicable to all Indemnity Claims including, for clarity, Identified Seller Indemnity Claims). If the indemnitor does not deliver a timely (*i.e.*, in accordance with Section 5.3(a)) Notice of Election that both (i) acknowledges its obligation to indemnify and hold the indemnitee harmless with respect to the Indemnity Claim, and (ii) in the case of any Indemnity Claim that is not an Identified Seller Indemnity Claim, includes an express election by the indemnitor to assume control of the defense and settlement of the Indemnity Claim, then the indemnitee may defend and/or settle the Indemnity Claim in such manner as it may deem appropriate at the cost and expense of the indemnitor, including payment of any settlement, judgment or award and the costs of defending or settling the Indemnity Claim. The indemnitor will promptly reimburse the indemnitee upon demand for all Losses suffered or incurred by the indemnitee as a result of or in connection with the Indemnity Claim.

(e) Cooperation regarding Indemnity Claims. The indemnitor and the indemnitee shall provide reasonable cooperation with one another in connection with the defense and resolution of any Indemnity Claim, provided that any costs incurred by the indemnitee in connection with such cooperation shall be borne by the indemnitor, and shall be promptly reimbursed by the indemnitor upon demand from the indemnitee.

5.4 **Survival of Representations and Warranties and Indemnities.** All representations and warranties set forth herein, and the associated defense and indemnity obligations of the Indemnifying Party, shall survive the Closing and expire on the third (3^{rd}) anniversary of the Closing Date, except that (i) the representations and warranties set forth in Sections 2.1, 2.2, 2.3, 3.1, 3.2, and 3.3 (each a "***Fundamental Representation***"), and the associated defense and indemnity obligations of the Indemnifying Party, shall survive indefinitely, and (ii) the representations and warranties of Seller set forth in Section 2.4, and Seller's associated defense and indemnity obligations under Section 5.1, shall survive the Closing and expire on the fifth (5^{th}) anniversary of the Closing Date. If an Indemnified Party delivers to an Indemnifying Party a written notice of a claim for indemnity based upon a breach of any of the Indemnifying Party's representations or warranties set forth herein, then the applicable representation or warranty shall survive until, but only for purposes of, the resolution of the matter covered by such notice.

5.5 **Waivers of Closing Conditions.** Except as otherwise expressly provided herein, the rights to indemnification set forth in this ARTICLE V shall not be affected by any waiver by an Indemnified Party of any closing condition relating to the accuracy of any representations and warranties or the performance of or compliance with agreements and covenants.

ARTICLE VI

LIMITATIONS OF REMEDIES AND LIABILITY

Notwithstanding any other provisions of this APA to the contrary, Seller's and Buyer's remedies and liabilities shall be subject to the terms, limitations and exclusions set forth in this ARTICLE VI, each of which shall be applicable according to its terms to the maximum extent permitted according to applicable Law.

6.1 **Acknowledgments of Buyer and Seller.** Each of the Parties acknowledges and agrees that it is a sophisticated business entity, that it has been afforded ample opportunity to conduct due diligence in relation to, and to otherwise assess and evaluate, the transactions contemplated hereby, and that it considers the allocations of risk set forth in this APA to be reasonable and acceptable. Notwithstanding the preceding sentence, each Party shall be entitled to rely on the completeness and accuracy of the representations and warranties of the other Party given in this APA without regard to such Party's own knowledge or due diligence; provided, however, that in the event of a conflict between this Section 6.1 and any other provision of this Agreement, such other provision shall control.

6.2 **Buyer's Remedies Against Seller.**

(a) ***

6.3 **Seller's Remedies Against Buyer.**

(a) ***

ARTICLE VII

DEFINITIONS

7.1 **Defined Terms.** For purposes of this APA, each of the following terms shall have the meaning set forth below:

"***ABS Platform***" has the meaning specified in Section 1.1(a).

"***ABS Software***" means the Software identified as ABS Software on Schedule 1.1(a).

"Acquired Assets***" has the meaning specified in Section 1.1.

"***Acquired Seller Intellectual Property Rights***" has the meaning specified in Section 1.1(c).

"***Affiliate***" means any affiliate, as defined in Rule 12b-2 under the Securities Exchange Act of 1934, as amended.

"***Ancillary Agreements***" has the meaning specified in Section 1.5 and shall also include other documents to be executed and/or delivered in connection with the transactions contemplated herein and therein, but specifically excludes the MSA and the Initial SOWs and any other documents and instruments not directly governing and supporting the consummation of the transactions contemplated hereby.

"***AP Effective Date***" has the meaning specified in the preamble.

"***APA***" has the meaning specified in the preamble.

"***Authorized Users***" means Seller's and its Affiliates' and Service Recipients' employees and contractors who are authorized by Seller or its Affiliate to access or receive data of Seller or its Affiliate that is stored in or processed by the Acquired Assets.

"***Bill of Sale***" has the meaning specified in Section 1.5.

"***BPaaS Services***" has the meaning specified in the recitals.

"***BPaaS Services Commencement Date***" has the meaning specified in the MSA.

"***Business Associate Agreement***" means the Business Associate Agreement between Seller and Buyer entered into contemporaneously with the MSA.

"***Business Day***" means a day other than a Saturday or Sunday or a public holiday on which the commercial banks are open for ordinary banking business in California.

"***Buyer***" has the meaning specified in the preamble.

"***Buyer Indemnitees***" has the meaning set forth in Section 5.1.

"***Buyer Material Adverse Effect***" means any change, event, circumstance or development that has or is reasonably likely to have a material adverse effect on the ability of Buyer to use and operate Acquired Assets as a whole after the Closing; except, in either case, when resulting from a change Law after the Closing.

"***Closing***" has the meaning set forth in Section 1.7.

"***Closing Condition***" and "***Closing Conditions***" have the respective meanings set forth in Section 1.10.

"***Closing Date***" has the meaning set forth in Section 1.7.

"***Code***" means the Internal Revenue Code of 1986, as amended.

"***Configurations***" means the Software configurations, settings and the like that Seller has made, and that Seller's contractors (including Buyer) have made on Seller's behalf, to configure and tailor, for use in Seller's business, Software that Seller licenses from third parties and which interacts with the ABS Platform.

"***Copyright Assignment Agreement***" has the meaning specified in Section 1.5.

"***Corporate Documents***" means the certificate of organization, certificate of incorporation, operating agreement, bylaws and other governing documents of Seller or Buyer, as the case may be.

"***Developed ABS Software***" means that Software comprising part of the ABS Platform which was developed for Seller by Seller's employees and contractors other than ICI.

"***Disclosure Schedule***" means the disclosure schedule provided by Seller to Buyer on the date hereof and attached hereto.

"***Dispute Date***" has the meaning specified in Section 9.1(a)(i).

"***Effective Time***" has the meaning specified in Section 1.7.

"***Excluded Assets***" has the meaning specified in Section 1.3.

"***Excluded Third Party Actions***" has the meaning specified in Section 5.1(a).

"***Final Allocation***" has the meaning specified in Section 4.2.

"***Fundamental Representation***" has the meaning specified in Section 5.4.

"***Governmental Entity***" means any court, arbitrational tribunal, administrative agency or commission or other governmental or regulatory authority or agency.

" ***

*** ***"***Indebtedness***" means all indebtedness of Seller for borrowed money, whether current or funded, or secured or unsecured, including (a) all obligations of Seller to banks or other institutional lenders pursuant to existing loan agreements; (b) all indebtedness of Seller for the deferred purchase price of property or services; (c) all indebtedness of Seller created or arising under any conditional sale or other title retention agreement with respect to property acquired by Seller (even though the rights and remedies of Seller or lender under such agreement in the event of default are limited to repossession or sale of such property); (d) all indebtedness of Seller secured by a purchase money mortgage or other Security Interest to secure all or part of the purchase price of the property subject to such mortgage or Security Interest; (e) all obligations under leases that have been or must be recorded as capital leases in respect of which Seller is liable as lessee; (f) any liability of Seller in respect of banker's acceptances or letters of credit; (g) all indebtedness referred to above that is directly or indirectly guaranteed by Seller or that Seller has agreed (contingently or otherwise) to purchase or otherwise acquire or in respect of which it has otherwise assured a creditor against loss; and (h) all interest, fees and other expenses owed with respect to the indebtedness referred to in clauses (a) through (g) above.

"***Indemnified Party***" has the meaning set forth in Section 5.3.

"***Indemnifying Party***" has the meaning set forth in Section 5.3.

"***Initial SOWs***" means the MSA Statements of Work listed on Exhibit D.

"***Injunction***" has the meaning specified in Section 6.2(d).

"***Intellectual Property Rights***" means:

(a) patents, patent applications, patent disclosures and all related continuation, continuation-in-part, divisional, reissue, reexamination, utility model, certificate of invention and design patents, patent applications, registrations and applications for registrations;

(b) trademarks, service marks, trade dress, Internet domain names, logos, trade names and corporate names and registrations and applications for registration thereof;

(c) copyrights and registrations and applications for registration thereof; and

(d) rights in inventions, whether patentable or non-patentable and whether or not reduced to practice, know-how, and rights in trade secrets and confidential information; and

(e) other proprietary rights relating to any of the foregoing (including remedies against infringements thereof and rights of protection of interest therein under the Laws of all jurisdictions).

"***Intellectual Property Rights Assignment and Assumption Agreement***" has the meaning specified in Section 1.5.

"***Knowledge***" means the actual knowledge of a Party's Knowledge Individuals after due inquiry.

"***Knowledge Individuals***" means, in the case of Buyer and Seller, respectively, the individuals identified as such on Schedule 7.1.

"***Law***" or "***Laws***" means all applicable laws (including common laws), statutes, rules, regulations, ordinances, judgments, orders, writs, injunctions, directives, decrees and other pronouncements having the binding effect of law of any Governmental Entity.

"***Legal Proceeding***" means any action, suit, proceeding, claim, arbitration or investigation before any Governmental Entity or before any arbitrator.

"***Losses***" means (a) in relation to Third Party Actions, (i) all awards and settlement payments to a third party in connection with a Third Party Action that are payable by an Indemnified Party, and (ii) costs of investigation and litigation (including attorneys' fees and costs) incurred by an Indemnified Party prior to the Indemnifying Party assuming responsibility for the defense and settlement of the Third Party Action, or awarded by a court or arbitrator to the claimant in the Third Party Action; and (b) in relation to any other claim in respect of which either Party is obligated to indemnify and hold harmless the other Party under ARTICLE V, the actual direct damages suffered or incurred by the injured Party and its Affiliates arising out of the event giving rise to the indemnity obligation, but not including any special, indirect, incidental, consequential, exemplary, or punitive damages, or any lost profits, lost revenues, lost business opportunities, lost or unproductive investments, diminution in value, or lost savings suffered or incurred by the injured Party and/or its Affiliates.

"***MSA***" means that certain Master Services Agreement dated as of November 2, 2014 between the Parties.

"***Ordinary Course of Business***" means the ordinary course of business consistent with past custom and practice (including with respect to frequency and amount).

"***Parties***" and "***Party***" have the meanings specified in the preamble.

"***Person***" means any legal or natural person, an individual, corporation, partnership, limited liability company, companies with unlimited liability, association, trust or other entity or organization, including a Governmental Entity.

"***Protected Health Information***" has the meaning specified in the Business Associate Agreement.

"***Purchase Price***" has the meaning specified in Section 1.6.

"***Retained Liabilities***" means any and all liabilities or obligations (whether known or unknown, absolute or contingent, liquidated or unliquidated, due or to become due and accrued or unaccrued, and whether claims with respect thereto are asserted before or after the Closing) of Seller. The Retained Liabilities shall include, for the avoidance of doubt and without limitation, all liabilities and obligations of Seller:

(a) for costs and expenses incurred in connection with the negotiation and drafting of this APA or the consummation of the transactions contemplated by this APA;

(b) under this APA, the MSA or the Ancillary Agreements;

(c) for any Taxes payable with respect to Seller's business or the Acquired Assets with respect to any taxable period or portion thereof ending on or before the Closing Date, or, with respect to Seller's business, on or after the Closing Date;

(d) arising out of events, conduct or conditions existing or occurring on or prior to the Closing Date that constitute a violation of or non-compliance with any Law, any judgment, decree or order of any Governmental Entity;

(e) arising with respect to any employee or former employee of Seller or any Affiliate of Seller;

(f) damage to or destruction of property of Seller occurring on or prior to the Closing Date;

(g) in respect of any and all Seller Indebtedness; and

(h) related to the ownership, operation and use of the Acquired Assets on or prior to the Closing Date.

"***Routine Liens***" has the meaning specified in Section 2.4(b).

"***Security Interest***" means any interest, mortgage, pledge, easement, assessment, security interest, lien, adverse claim, levy, charge or other encumbrance of any kind (whether voluntary or involuntary or whether arising by contract or by operation of Law).

"***Seller***" has the meaning specified in the preamble.

"***Seller Confidential Information***" means any non-public, commercially sensitive information (or materials) belonging to, concerning or in the possession or control of Seller or any of its Affiliates or Service Recipients that is furnished, disclosed or otherwise made available by (or on behalf of) Seller or any of its Affiliates or Service Recipients (directly or indirectly) to Buyer (or entities or persons acting on Buyer's behalf) in connection with this APA, including in connection with the delivery of the Acquired Assets to Buyer, and which is (a) marked or identified in writing as confidential, proprietary, secret or with another designation sufficient to give notice of its sensitive nature, or (b) identifiers of Seller or a Seller Affiliate or Service Recipient or other descriptions that would enable a viewer of the information to specifically associate the marking with Seller or a specific Seller Affiliate or Service Recipient, or (c) is of a type that a reasonable person would recognize it to be proprietary or commercially sensitive to Seller or a Seller Affiliate or Service Recipient. For the avoidance of doubt "***Seller Confidential Information***" may include any (i) information meeting any of the foregoing criteria to which Buyer has access in Seller facilities or systems (or those of any Seller Affiliates or Service Recipients) operated by Buyer for Seller or otherwise accessed by Buyer to provide services to Seller and its Affiliates, (ii) Seller Data, Seller Owned Software and Seller Licensed Software other than the ABS Software, and systems access codes, (iii) information concerning Seller's and/or its Affiliates' and/or Service Recipients' products, marketing strategies, financial affairs, employees, customers or suppliers, (iv) personal information and personally

identifiable information of Seller's employees and members and any other information protected under the Business Associate Agreement (including Protected Health Information), and (v) those components of the Proprietary Business Rules that are identified in Schedule 1.3 as "HN IP", in each case regardless of whether or how any of the foregoing is marked. "Seller Confidential Information" shall not include any particular information (other than personal information, personally identifiable information and Protected Health Information) of Seller that Buyer can demonstrate: (i) was rightfully in the possession of, or was rightfully known by, Buyer without an obligation to maintain its confidentiality prior to receipt from Seller; (ii) was or has become generally known to the public other than as a result of breach of this Agreement or a wrongful disclosure by Buyer or any of its agents; (iii) after disclosure to Buyer, was received from a third party who, to Buyer's knowledge, had a lawful right to disclose such information to Buyer without any obligation to restrict its further use or disclosure; or (iv) was independently developed by Buyer without use of or reference to any Confidential Information of Seller.

"***Seller Data***" means all data and information in any form, whether or not Seller Confidential Information, (i) entered in Software or equipment, directly or indirectly, by or on behalf of Seller, a Seller Affiliate, a former Seller Affiliate or any licensee, customer, provider (e.g., physician, medical group, hospital, etc.) contractor or other entity with which Seller has a business relationship, including derivative works of such data and information produced by, for or on behalf of Seller, (ii) directly or indirectly obtained by Buyer from, in connection with, or as a result of the Services provided by the Buyer under the MSA, or (iii) derived from either (i) or (ii).

"***Seller Indemnitees***" has the meaning set forth in Section 5.2.

"***Seller Licensed Software***" means Software owned (*i.e.*, in which the copyright is owned) by a party other than Seller (or a Seller Affiliate) that is licensed by Seller (or a Seller Affiliate).

"***Seller Owned Software***" means Software, other than the ABS Software, owned (*i.e.*, in which the copyright is owned) by Seller (or a Seller Affiliate).

"***Seller Material Adverse Effect***" means any change, event, circumstance or development that has or is reasonably likely to have a material adverse effect on, (a) the Acquired Assets as a whole, or (b) the ability of Buyer to use and operate Acquired Assets as a whole immediately after the Closing in the same manner as Seller used and operated the Acquired Assets immediately prior to the Closing; except, in either case, when resulting from a change in Law.

"***Service Recipient***" means any of the following who are designated by Seller from time to time as recipients of Services under the MSA: Seller's Affiliates, former Seller Affiliates, licensees, customers, providers (e.g., physicians, medical groups, hospitals, etc.), contractors and other entities with which Seller has a business relationship.

"***Software***" means (i) program code, in binary object code (machine language) form and source code (programming language) form and all supporting documentation, media, on-line help facilities and tutorials, including any updates thereto, (ii) frameworks, utilities, macros, Software configurations, templates and tools used to deliver services or enhance the productivity or quality of services, and (iii) derivative works of any item described in clauses (i) and (ii).

"***Taxes***" means all taxes and similar charges, fees, levies or assessments, including income, gross receipts, ad valorem, premium, value-added, excise, real property, personal property sales, use, harmonized sales, goods and service, transfer, withholding (including withholding taxes on payments

to or from Seller), employment, unemployment, insurance, social security, business license, business organization, environmental, workers compensation, payroll, profits, license, lease, service, service use, severance, stamp, occupation, windfall profits, customs, duties, franchise and other taxes imposed by the United States of America or any state, local or foreign government, or any agency thereof, or other political subdivision of the United States or any such government, and any interest, fines, penalties, assessments or additions to tax resulting from, attributable to or incurred in connection with any tax or any contest or dispute thereof.

"***Third Party Action***" means any claims, actions, suits, complaints, petitions, inquiries, proceedings, hearings or investigations by a Person or entity other than Buyer or Seller for which indemnification may be sought by a party under ARTICLE V.

"***Third Party Materials***" has the meaning specified in Section 2.4(b).

"***Transfer Taxes***" has the meaning specified in Section 4.2.

"***UCITA***" has the meaning specified in Section 9.6.

"***Use***" means the right of a Party, through its employees and contractors, to use, execute, display, copy, perform, distribute copies of, maintain, modify, enhance and create derivative works of the subject licensed materials.

ARTICLE VIII

RULES OF CONSTRUCTION

8.1 **Entire Agreement.** This APA, including its attached Exhibits and Schedules and the Ancillary Agreements, constitutes the entire agreement between the Parties with respect to its subject matter and merges, integrates and supersedes all prior and contemporaneous agreements and understandings between the Parties, whether written or oral, concerning its subject matter.

8.2 **Contracting Parties; No Third Party Beneficiaries.** This APA is entered into solely between, and may be enforced only by, Seller and Buyer and their respective successors and permitted assigns. This APA does not create any legally enforceable rights in third parties, including suppliers, subcontractors and customers of a Party, except as provided in ARTICLE V with respect to Buyer Indemnitees and Seller Indemnitees.

8.3 **Amendments and Modifications.** Any terms and conditions varying from this APA on any document or written notification from either Party will not be effective or binding on the other Party. This APA may be amended or modified solely in a writing signed by an authorized representative of each Party.

8.4 **Governing Law.** This APA and performance under it shall be governed by and construed in accordance with the laws of the state of California without regard to its choice of law principles.

8.5 **Consents and Approvals.** Where approval, acceptance, consent or similar action by either Party is required under this APA, such action will not be unreasonably delayed, conditioned or withheld unless this APA expressly provides that it is in the discretion of the Party. No approval or consent given by a Party under this APA will relieve the other Party from responsibility for complying

with the requirements of this APA, nor will it be construed as a waiver of any rights under this APA (except to the extent, if any, expressly provided in such approval or consent). Each Party will, at the request of the other Party, perform those actions, including executing additional documents and instruments, reasonably necessary to give full effect to this APA and the transactions contemplated hereby.

8.6 **Waiver.** No failure or delay by a Party in exercising any right, power or remedy will operate as a waiver of that right, power or remedy, and no waiver will be effective unless it is in writing and signed by an authorized representative of the waiving Party. If a Party waives any right, power or remedy, the waiver will not waive any successive or other right, power or remedy that Party may have.

8.7 **Remedies Cumulative.** Except as otherwise expressly provided in this APA, all remedies provided in this APA are cumulative and in addition to and not in lieu of any other remedies available to a Party under this APA, at law or in equity.

8.8 **References**.

(a) The section headings and the table of contents used in this APA are for convenience of reference only and will not enter into the interpretation of this APA.

(b) References to numbered (or lettered) articles and sections of this APA also refer to and include all subsections of the referenced article or section.

(c) Unless otherwise indicated, references to Exhibits and Schedules to this APA also refer to and include all attachments to the referenced Exhibit or Schedule.

(d) Unless the context requires otherwise, "***including***" (and any of its derivative forms) means including, but not limited to.

8.9 **Order of Precedence.** If there is any conflict between this APA and any of the Ancillary Agreements, the Parties shall attempt to read any such conflicting provisions consistently; however, in the event such a consistent reading cannot be accomplished, this APA shall control.

8.10 **Severability.** If any provision of this APA conflicts with the Law under which this APA is to be construed or if any provision of this APA is held invalid, illegal or otherwise unenforceable by a competent authority, such provision will, if possible, be deemed to be restated to reflect as nearly as possible the original intentions of the Parties in accordance with applicable Law. In any event, the remainder of this APA will remain in full force and effect.

8.11 **Counterparts.** This APA may be executed in several counterparts and by facsimile or PDF signature, all of which taken together constitute a single agreement between the Parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (including facsimile and PDF), will be considered as legally effective as an original signature.

8.12 **Reading Down.** If a provision of this APA is reasonably capable of an interpretation which would make that provision valid, lawful and enforceable and an alternative interpretation that would make it unenforceable, illegal, invalid or void then, so far as is possible, that provision will be interpreted or construed to be limited and read down to the extent necessary to make it valid and enforceable.

ARTICLE IX

DISPUTE RESOLUTION

Any dispute between the Parties arising out of or relating to this APA, including with respect to the interpretation of any provision of this APA or with respect to performance by a Party, will be resolved as provided in this ARTICLE IX.

9.1 **Informal Dispute Resolution**.

(a) Subject to Section 9.1(b), the Parties initially will attempt to resolve any dispute arising out of or relating to this APA informally in accordance with the following:

(i) Within ten (10) days after a Party receives notice of a dispute from the other Party ("***Dispute Date***"), it will designate a senior representative (*i.e.*, in the case of Buyer, ***, and in the case of Seller, Vipul Khanna (or his designee), who will offer to meet with the designated senior representative of the other Party for the purpose of attempting to resolve the dispute amicably. All communications pursuant to this Section 9.1(a) shall be deemed communications covered by and subject to Federal Rule of Evidence 408 and provisions to similar effect under New York Law and, accordingly, any such communications shall not be admissible in court as evidence against either Party.

(ii) The appointed representatives will meet promptly to discuss the dispute and attempt to resolve it without the necessity of any formal proceeding. They will meet as often as the Parties deem necessary in order that each Party may be fully advised of the other's position. During the course of discussion, all reasonable requests made by one Party to the other for non-privileged information reasonably related to the matters in dispute will be honored promptly.

(iii) The specific format for the discussions will be left to the discretion of the appointed representatives.

(b) Formal dispute resolution may be commenced by a Party upon the first to occur of any of the following:

(i) the appointed representatives conclude in good faith that amicable resolution of the dispute through continued negotiation does not appear likely;

(ii) seven (7) days have passed from the Dispute Date (this period will be deemed to run notwithstanding any claim that the process described in this Section 9.1 was not followed or completed); or

(iii) commencement of formal dispute resolution is deemed necessary by a Party to avoid the expiration of an applicable limitations period or to preserve a superior position with respect to other creditors, or a Party makes a good faith determination, including as provided in Section 9.4, that a breach of this APA by the other Party is such that a temporary restraining order or other injunctive or conservatory relief is necessary.

(c) All timeframes specified in this Section 9.1 are not-to-exceed durations. In the event of disputes related to compliance with Laws, either Party may require the other Party (and the

other Party shall comply with) shorter timeframes as needed in order for the Party to respond to any regulator or regulatory deadlines.

9.2 **Arbitration.** Any dispute between the Parties arising out of or relating to this APA that is not resolved pursuant to Section 9.1 shall be finally settled by mandatory and binding arbitration administered by the American Arbitration Association ("***AAA***") in accordance with its then-effective Commercial Arbitration Rules (the "***Rules***") and in accordance with the following:

(a) One (1) arbitrator shall be appointed in accordance with the Rules. Either Party may initiate arbitration by submitting a written request for arbitration to the AAA and the other Party, setting forth in reasonable detail the subject of the dispute and the relief requested.

(b) The arbitration shall be conducted in accordance with the Rules, provided that to the extent this Section 9.2 modifies, supplements or is inconsistent with the Rules, this Section 9.2 will govern. The arbitrator shall have no power or authority to amend or disregard any provision of this Section 9.2 or any other provision of this Agreement. The arbitration hearing shall be commenced promptly and conducted expeditiously, with each Party being allocated one-half of the time for the presentation of its case.

(c) Unless otherwise agreed by the Parties, arbitration hearings hereunder shall be held in Los Angeles, California. The language of the arbitration shall be English. Unless otherwise agreed by the Parties, an arbitration hearing shall be conducted on consecutive days. The Parties will participate in the arbitration in good faith, and will share equally in the administrative costs of the arbitration; provided however, that each Party will pay its own attorneys' fees (subject to the next sentence). The arbitrator may, in his or her discretion, award the prevailing Party its attorneys' fees and out-of-pocket expenses, including its share of the arbitration fees.

(d) Recognizing the express desire of the Parties for an expeditious means of dispute resolution, each Party will, upon the written request of the other Party, promptly provide the other with copies of documents relevant to the issues raised by the dispute.

(e) The Parties shall be permitted to conduct reasonable discovery, and each Party will be entitled to conduct up to ten (10) hours of depositions.

(f) The arbitrator will have full power and authority to determine issues of arbitrability and to interpret or construe the applicable provisions of this Agreement.

(g) The award shall be made within thirty (30) days of the completion of the arbitration hearing.

(h) Each Party shall submit to the arbitrator and exchange with each other not less than seven (7) days prior to the scheduled hearing date their last, best offers, along with a brief and documentation in support of their offer. The arbitrator shall have the authority to limit the length of such submissions.

(i) The arbitrator's decision shall be final and binding on the Parties, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

9.3 **Continued Performance.** Each Party agrees (a) to continue performing its obligations under this APA while a dispute is being resolved except (and then only) to the extent performance is

prevented by the other Party or the issue in dispute precludes performance, and (b) not to take any action that intentionally obstructs, delays or reduces in any way the performance of such obligations. For the avoidance of doubt, this Section 9.3 shall not be interpreted to limit either Party's right to terminate this APA (in whole or in part) as provided in Section 1.10.

9.4 **Equitable Remedies.** Each Party acknowledges that a breach of any of its obligations under this APA, or its infringement or misappropriation of any Intellectual Property Rights of the other Party, may irreparably harm the other Party in a way that could not be adequately compensated by money damages. In such a circumstance, the aggrieved Party may (in addition to all other remedies and rights) proceed directly to court, as provided in Section 9.2, notwithstanding the other provisions of this ARTICLE IX. If the court should find that a Party has breached (or attempted or threatened to breach) any such obligations, such Party agrees that without posting bond or proving damages and without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling its performance of such obligations and restraining it from any further breaches (or attempted or threatened breaches) of such obligations.

9.5 **WAIVER OF JURY TRIAL**. TO THE EXTENT NOT PROHIBITED BY APPLICABLE LAW WHICH CANNOT BE WAIVED, EACH PARTY HEREBY WAIVES, AND COVENANTS THAT IT WILL NOT ASSERT (WHETHER AS PLAINTIFF, DEFENDANT OR OTHERWISE), ANY RIGHT TO TRIAL BY JURY IN ANY FORUM IN RESPECT OF ANY ISSUE, CLAIM, DEMAND, ACTION OR CAUSE OF ACTION ARISING OUT OF OR BASED UPON THIS AGREEMENT, THE SUBJECT MATTER HEREOF, ANY OTHER FUNDAMENTAL DOCUMENT OR THE SUBJECT MATTER THEREOF, IN EACH CASE WHETHER NOW EXISTING OR HEREAFTER ARISING AND WHETHER IN CONTRACT OR TORT OR OTHERWISE. EACH PARTY ACKNOWLEDGES THAT IT HAS BEEN INFORMED BY THE OTHER PARTIES HERETO THAT THE PROVISIONS OF THIS SECTION CONSTITUTE A MATERIAL INDUCEMENT UPON WHICH SUCH OTHER PARTIES HAVE RELIED, ARE RELYING AND WILL RELY IN ENTERING INTO THIS AGREEMENT AND ANY OTHER FUNDAMENTAL DOCUMENT. ANY PARTY MAY FILE AN ORIGINAL COUNTERPART OR A COPY OF THIS SECTION 9.5 WITH ANY COURT AS WRITTEN EVIDENCE OF THE CONSENT OF ANY CREDIT PARTY TO THE WAIVER OF ITS RIGHTS TO TRIAL BY JURY.

9.6 **Disclaimer of the Uniform Computer Information Transactions Act.** TO THE MAXIMUM EXTENT PERMITTED UNDER APPLICABLE LAW, THE PARTIES DISCLAIM AND NONE OF THIS APA SHALL BE SUBJECT TO THE UNIFORM COMPUTER INFORMATION TRANSACTIONS ACT ("***UCITA***") (PREPARED BY THE NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS) AS CURRENTLY ENACTED OR AS MAY BE ENACTED, CODIFIED OR AMENDED FROM TIME TO TIME BY ANY JURISDICTION. TO THE EXTENT THAT ANY ASPECT OF THIS APA OR ANY LICENSE GRANTED UNDER THIS APA IS UNCLEAR OR DISPUTED BY THE PARTIES AND UCITA, IF APPLIED, WOULD CLARIFY SUCH LICENSE OR RESOLVE SUCH DISPUTE, THE PARTIES AGREE TO CLARIFY SUCH LICENSE OR RESOLVE SUCH DISPUTE INDEPENDENTLY OF UCITA BY APPLYING THE INTENT OF THE PARTIES AT THE TIME THAT THEY ENTERED THIS APA.

ARTICLE X

GENERAL

10.1 **Binding Nature and Assignment.** This APA is binding on the Parties and their respective successors and permitted assigns. Neither Party may assign this APA or delegate its rights or obligations under this APA without the prior written consent of the other Party. Any attempted assignment in violation of this Section 10.1 will be void and will constitute a material breach of this APA by the Party attempting the assignment.

10.2 **Notices.** All notices, requests, demands and determinations under this APA (other than routine operational communications), shall be in writing and shall be deemed duly given (i) when delivered by hand, (ii) on the designated day of delivery after being timely given to an express overnight courier with a reliable system for tracking delivery, (iii) six days after the day of mailing, when mailed by United States mail, registered or certified mail, return receipt requested and postage prepaid, and addressed as follows:

If to Seller

Health Net, Inc.
21650 Oxnard Street
Woodland Hills, CA 91367
Attn: James E. Woys

Copy to:

Health Net, Inc.
21650 Oxnard Street
Woodland Hills, CA 91367
Attn: General Counsel

and to:

Pillsbury Winthrop Shaw Pittman LLP
2300 N Street, N.W.
Washington, DC 20037
Fax: (202) 663-8007
Attn: Joseph E. Kendall

If to Buyer:

Cognizant Healthcare Services, LLC
500 Frank W. Burr Boulevard
Teaneck, NJ 07666
Fax: (201) 801-0243
Attn: General Counsel

Copy to:

Reed Smith LLP
599 Lexington Avenue
New York, NY 10022
Fax: (212) 521-5450
Attn: Yvan-Claude Pierre

10.3 **Covenant of Good Faith.** Each Party, in its respective dealings with the other Party under or in connection with this APA, will act reasonably and in good faith.

10.4 **Public Disclosures.** Neither Party shall make any media releases, public announcements or public disclosures relating to this APA or the subject matter of this APA, including promotional or marketing material, but not including disclosures to the extent required to meet legal or regulatory requirements beyond the reasonable control of the disclosing Party, without the prior written consent of the other Party.

10.5 **Expenses.** Each Party shall bear its own costs and expenses (including legal fees and expenses) incurred in connection with this APA and the transactions contemplated hereby.

Remainder of Page Intentionally Blank

IN WITNESS WHEREOF, the Parties have duly executed this APA as of the date first above written.

COGNIZANT HEALTHCARE SERVICES, LLC

By: /s/ Steven Schwartz
Name: Steven Schwartz
Title: Executive Vice President Chief Legal and Corporate Affairs Officer

Signature Page to Asset Purchase Agreement

IN WITNESS WHEREOF, the Parties have duly executed this APA as of the date first above written.

HEALTH NET, INC.

By: /s/ James E. Woys
Name: James E. Woys
Title: EVP, COO & CFO

Signature Page to Asset Purchase Agreement

Exhibit 21

Subsidiaries of Health Net, Inc. as of February 20, 2015

Health Net, Inc. (DE) (95-4288333)
(All Subsidiaries wholly owned unless otherwise indicated)

- Health Net of California, Inc. (CA) (95-4402957)
  - Health Net Life Insurance Company (CA) (73-0654885)
  - Health Net Life Reinsurance Company (Cayman Islands) (98-0409907)
  - Health Net of California Real Estate Holdings, Inc. (CA) (54-2174069)
- Health Net Access, Inc. (AZ) (46-2616037)
- Health Net Community Solutions, Inc. (CA) (54-2174068)
- Health Net of the Northeast, LLC (DE) (06-1116976)[1]
- Health Net Foundation, Inc. (DE) (41-2241862)[2]
- QualMed, Inc. (DE) (84-1175468)
  - QualMed Plans for Health of Colorado, Inc. (CO) (84-0975985)
  - Health Net Health Plan of Oregon, Inc. (OR) (93-1004034)
- HSI Advantage Health Holdings, Inc. (DE) (23-2867299)
  - QualMed Plans for Health of Western Pennsylvania, Inc. (PA) (23-2867300)
  - Pennsylvania Health Care Plan, Inc. (PA) (25-1516632)
- Health Net of Pennsylvania, LLC (PA)
- FH Surgery Limited, Inc. (CA) (68-0390434)
- FH Surgery Centers, Inc. (CA) (68-0390435)[3]
  - Greater Sacramento Surgery Center Limited Partnership (CA) (68-0343818)[3]
- Foundation Health Facilities, Inc. (CA) (68-0390438)
- FH Assurance Company (Cayman Islands) (98-0150604)
- Health Net Federal Services, LLC (DE) (68-0214809)
  - Health Net Preferred Providers, LLC (DE) (61-1388903)
  - Network Providers, LLC (DE) (88-0357895)[1,4]
  - Health Net Veterans LLC (DE) (35-2490375)
- Health Net Pharmaceutical Services (CA) (68-0295375)
- Health Net of Arizona Administrative Services, Inc. (AZ) (86-0660443)
- Health Net of Arizona, Inc. (AZ) (36-3097810)

Exhibit 21

- Managed Health Network, Inc. (DE) (95-4117722)
  - Managed Health Network (CA) (95-3817988)
  - MHN Services (CA) (95-4146179)
    - MHN Services IPA, Inc. (NY) (13-4027559)
    - MHN Government Services, Inc. (DE) (42-0680916)[4]
      - MHN Global Services, Inc. (DE) (51-0589404)
      - MHN Government Services – Belgium, Inc. (DE) 80-0852000
      - MHN Government Services – Djibouti, Inc. (DE) 90-0889816
      - MHN Government Services – Germany, Inc. (DE) 80-0852008
      - MHN Government Services – Guam, Inc. (DE) 90-0889803
      - MHN Government Services – International, Inc. (DE) 90-0889825
      - MHN Government Services – Italy, Inc. (DE) 80-0852019
      - MHN Government Services – Japan, Inc. (DE) 46-1038058
      - MHN Government Services – Puerto Rico, Inc. (DE) 90-0889815
      - MHN Government Services – Turkey, Inc. (DE) 90-0889824
      - MHN Government Services – United Kingdom, Inc. (DE) 90-0889833
  - Catalina Behavioral Health Services, Inc. (AZ) (51-0490598)
- Health Net Services, Inc. (DE) (94-3037822)
- National Pharmacy Services, Inc. (DE) (84-1301249)[5]
  - Integrated Pharmacy Systems, Inc. (PA) (23-2789453)[5]
- QualMed Plans for Health of Pennsylvania, Inc. (PA) (23-2456130)
- Health Net One Payment Services, Inc. (DE) (54-2153100)

____

1. Health Net, Inc. owns 75% and Network Providers, LLC owns 25% of the outstanding equity interests of Health Net of the Northeast, LLC
2. Health Net Foundation, Inc. is a nonprofit, nonstock corporation exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.
3. FH Surgery Centers, Inc. owns general and limited partnership units, representing approximately 66% of the total equity of Greater Sacramento Surgery Center Limited Partnership (which specific percentage fluctuates from time to time).
4. MHN Government Services, Inc. owns 10% of the equity interests in Network Providers, LLC
5. National Pharmacy Services, Inc. owns approximately 90% of the outstanding common stock of Integrated Pharmacy Systems, Inc.

Exhibit 23

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statements File Nos. 333-200940, 333-176241, 333-162122, 333-134014, 333-132008, 333-124900, 333-118647, 333-118646, 333-99337, 333-68387, 333-48969, 333-35193, 333-24621 on Form S-8 and 333-142960, 333-141311 and 333-02788 on Form S-3 of our reports dated February 27, 2015, relating to the consolidated financial statements and the financial statement schedule of Health Net, Inc. and subsidiaries (the “Company”) and the effectiveness of the Company’s internal control over financial reporting appearing in the Annual Report on Form 10-K of the Company for the year ended December 31, 2014.

/s/ Deloitte & Touche LLP

Los Angeles, California
February 27, 2015

Exhibit 31.1

Certification of Chief Executive Officer
Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, Jay M. Gellert, certify that:

1. I have reviewed this annual report on Form 10-K of Health Net, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process summarize and report financial information; and
   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 27, 2015

/S/ JAY M. GELLERT

Jay M. Gellert
President and Chief Executive Officer

Exhibit 31.2

Certification of Chief Financial Officer
Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

I, James E. Woys, certify that:

1. I have reviewed this annual report on Form 10-K of Health Net, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process summarize and report financial information; and
   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 27, 2015

/S/ JAMES E. WOYS

James E. Woys

Executive Vice President, Chief Financial and Operating Officer and Interim Treasurer

Exhibit 32

Certification of CEO and CFO Pursuant to
18 U.S.C. Section 1350,
as adopted pursuant to
Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Annual Report of Health Net, Inc. (the "Company") on Form 10-K for the year ending December 31, 2014 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), Jay M. Gellert, as Chief Executive Officer of the Company, and James E. Woys, as Chief Financial Officer of the Company, each hereby certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to the best of his knowledge, respectively:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

/s/ Jay M. Gellert

Jay M. Gellert
Chief Executive Officer

February 27, 2015

/s/ James E. Woys

James E. Woys
Executive Vice President, Chief Financial and Operating Officer and Interim Treasurer

February 27, 2015

CALIFORNIA REINVESTMENT COALITION

January 29, 2016

The Honorable Dave Jones
Insurance Commissioner
California Department of Insurance
300 Capitol Mall, 17th Floor
Sacramento, CA 95814

Re: *Proposed Acquisition of Health Net by Centene Corporation: File No. APP-2015-00889*

Dear Commissioner Jones,

The California Reinvestment Coalition submits these comments to inform your deliberations regarding the proposed acquisition of Health Net by Centene Corporation. We urge you to consider the questionable record of these companies not only with regard to their problematic impact on policyholders, but also with regard to their apparent failure to make any safe and sound investments in projects that address the critical affordable housing and community development needs of our state.

To that end, we offer evidence that the companies have failed to participate at all in the California Department of Insurance COIN program and other investment opportunities that would support a "double bottom line" proposition. As such, we urge the Commissioner to reject this proposed merger as contrary to the public interest, unless the companies will make a substantial commitment to "double bottom line" investments that are safe and sound, that support affordable housing and economic development in our state, and that contribute to strengthening the housing and health of the consumers who are impacted by these two companies. The overwhelming amount of research now connecting health to affordable housing should not be overlooked in this merger.

Insurance Code §1215.2(d)(5) provides that the Commissioner may disapprove the transaction if the Commissioner finds that "the competence, experience, and integrity of those persons who would control the operation of the insurer indicate that it would not be in the interest of the policyholders ***or the public*** to permit them to do so" (emphasis added). We do not believe the Applicants have established that this transaction will further the interests of policyholders or the public.

The California Reinvestment Coalition. The California Reinvestment Coalition (CRC), based in San Francisco, is a nonprofit membership organization of nonprofit organizations and public agencies across the state of California. We work with community-based organizations to promote the economic revitalization of California's low-income communities and communities of color through access to financial institutions. CRC promotes increased access to credit and investment for affordable housing and economic development for these communities.

We have a number of concerns with the proposed transaction:

Health Net may owe the state of California $923 Million in back taxes. As an initial matter, we note for the record that, according to a recent article by the San Jose Mercury News, Health Net may have wrongfully avoided paying a state constitutional tax requiring insurers to pay 2.35% on premiums collected, or an estimated $923 Million in unpaid taxes by Health Net. Health Net and other insurers dispute that they are subject to this tax, and the case is currently in litigation.[1]

The Commissioner must ensure that, should a court determine that Health Net wrongfully failed to pay taxes and Health Net is required to or otherwise agrees to pay this tax, Health Net will NOT be permitted to pass these costs on to Health Net policy holders or consumers.

The January 22, 2016 Hearing raised a number of concerning issues regarding treatment of policyholders and consumers. CRC supports the concerns raised at the January 22, 2015 Hearing by Consumer Watchdog, Consumers Union and Health Access, delineating a number of issues relating to actual (and potential) harmful impacts on consumers by the companies (and the proposed merger). Some of the issues raised include concerns relating to: high levels of consumer complaints, multi-million dollar pay and stock compensation to the company CEO and CFO, plan reductions and cancellations, unwarranted rate increases, poor customer service, fines imposed, limited access for customers who have Limited English Proficiency, and a lack of clarity regarding the level of enforceability of any undertakings or commitments made by the Applicants.

During the Hearing, the Applicants indicated a vague commitment to serving low and moderate income consumers. CRC questions this commitment, and urges a much stronger and clearer commitment by the Applicants to LMI consumers and communities.

The investment policies of Health Net and Centene fail to take advantage of the COIN program and other opportunities to make safe and sound investments that also provide a public or community benefit to California communities. Insurance companies collect billions of dollars in premiums, and must invest these dollars in safe and sound investments. But insurers have an important opportunity, and, we would argue, duty, to not only invest in a fiscally responsible manner, but to do so in projects and initiatives that help build affordable housing, promote economic development and job creation, and otherwise revitalize communities.

This transaction is occurring in the context of a severe affordable housing crisis in California. According to the California Housing Partnership Corporation, the state's shortfall of 1.54 million rental homes for extremely low-income (ELI) and very low-income (VLI) renter households contributes substantially to California's 22% poverty rate, the highest poverty rate of any state.[2]

[1] Tracy, Seipel, "California's four largest health plans could owe state $10 billion in back taxes," San Jose Mercury News, January 21, 2016.
[2] California Housing Partnership Corporation, "Update on California's Affordable Housing Crisis: The Critical Role of Access and Affordability in Reducing Poverty," April 2015, p. 3.

And there is a clear connection between housing and health stability. In a recent review of relevant research and literature, the Center for Housing Policy explored no less than ten pathways through which affordable housing influences the health of people of all ages. This report shows that providing affordable housing is a valuable strategy to support and improve well-being and that it is important for policymakers to understand that safe, adequate, and affordable housing is not just shelter but also an investment in good health for low-income households.[3]

In a large scale study conducted in 2009 in Los Angeles County, researchers compared the costs of providing supportive housing to homeless people to the costs that homeless persons with similar characteristics imposed on government resources. The researchers found that the public cost savings of providing supportive housing was $1,190 per person per month.[4]

The Robert Woods Johnson Foundation has also documented the extensive linkages between quality, affordable housing and health in the context of the physical conditions within homes, conditions in neighborhoods, and housing affordability. In reviewing numerous studies, the Foundation noted that poor quality and inadequate housing contributes to health problems such as infectious and chronic diseases, injuries and poor childhood development. Further, the social, physical and economic characteristics of neighborhoods have been increasingly shown to affect short term and long term health quality and longevity. Additionally, the shortage of affordable housing relegates low income households to unsafe, overcrowded neighborhoods, and places a financial strain on families that leaves them unable to meet other basic needs such as health care and nutrition.[5]

In the midst of this affordable housing crisis and its clear and substantial impact on the health of California and Californians, the Department of Insurance through its COIN program provides a ready-made and simple pathway for insurance companies to make safe and sound investments that also help address California's critical housing and other community development needs. In fact, "COIN was established in 1996 at the request of the insurance industry as an alternative to state legislation that would have required insurance companies to invest in underserved communities, similar to the federal Community Reinvestment Act (CRA) that applies to the banking industry."[6]

But what have Health Net and Centene done to help meet the needs of California's environment and its low to moderate income and rural communities?

---

[3] Nabihah Maqbool, Janet Viveiros, and Mindy Ault "The Impacts of Affordable Housing on Health: A Research Summary," Center for Housing Policy: Insights from Housing Policy Research, April 2015, available at: http://www2.nhc.org/HSGandHealthLitRev_2015_final.pdf

[4] Lisa Sturtevant and Janet Viveiros, "How Investing in Housing Can Save On Health Care: A Research Review and Comment on Future Directions for Integrating Housing and Health Services," National Housing Conference's Housing + Health Innovations in the Field, January 2016, p. 7.

[5] Paula Braveman, M.D., M.P.H., Mercedes Dekker, M.P.H., Susan Egerter, Ph.D., Tabashir Sadegh-Nobari, M.P.H. (all with University of California, San Francisco Center on Disparities in Health) and Craig Pollack, M.D., M.H.S. (Johns Hopkins School of Medicine), "Exploring the Social Determinants of Health," Robert Woods Johnson Foundation, Issue Brief 7, May, 2011.

[6] COIN "About Us," available at: http://www.insurance.ca.gov/0250-insurers/0700-coin/05-About-Us/

According to the most recent California Department of Insurance report:

- In 2012, Health Net Inc. and Health Net Life reported over $1 Billion in premiums in CA. Centene reported over $3 Million in premiums.

- But with regard to making investments that "provide a positive environmental or social impact to low-to-moderate income (LMI) households or areas, as well as rural and reservation based communities in California"….

    - Health Net reported ZERO "High Impact Holdings;"

    - Centene reported ZERO "High Impact Holdings;"

    - Health Net reported ZERO "COIN Qualified Holdings;"

    - Centene reported ZERO "COIN Qualified Holdings;"[7]

    - Health Net had ZERO participation in the state COIN CDFI Tax Credit Investment Program, going all the way back to 1997;

    - Centene had ZERO participation in the state COIN CDFI Tax Credit Investment Program, going all the way back to 1997.[8]

This raises the question - have Health Net or Centene made any "double bottom line" investments since 2012? If not, why not? The Commissioner should consider and review the response to this question before making a decision on the proposed merger. We understand that the Department currently has put out a data call asking for information about any such investments since 2012. If the companies have not responded to this data call as of yet, the Commissioner should ask that they do so in the short term, and before any decision on the proposed merger is rendered.

The primary question we raise in the context of this transaction is whether these companies will make a clear, substantial, and public commitment to participate in the state COIN program, as well as other double bottom line investments, so as to make safe and sound investments that will also contribute to the state's efforts to meet critically needed affordable housing, which also has demonstrable impacts on Californian's health care needs?

We urge the companies to make such a significant commitment to invest in affordable housing in California and to participate in the COIN program. In the absence of that, we urge the Commissioner to disapprove of this merger proposal as being contrary to the public interest.

---

[7] Insurer Investments and 2012 Data Call Results available at: http://www.insurance.ca.gov/0250-insurers/0700-coin/upload/2012-Insurer-COIN-Holdings.pdf
[8] COIN CDFI Tax Credit Investment Report (1997-2015) by Year, available at: http://www.insurance.ca.gov/0250-insurers/0700-coin/upload/CDFI-Investments-19972015-by-year.pdf

Thank you for the opportunity to comment. If you have any questions, you can reach me at (415) 864-3980.

Very Truly Yours,

Kevin Stein
Associate Director

Cc: Jennifer Chambers, sent via email at Jennifer.Chambers@insurance.ca.gov