Frequently Asked Questions
for Raytheon Employees

CUSTOMER SERVICE

How and when can I contact the health plan?

Telephone customer service representatives are available between 8:00 a.m. and 6:00 p.m. Pacific Time and Health Net's dedicated Member Services line for Raytheon employees can be reached at 1-800-628-2695.

What are your customer service hours?

8:00 a.m.- 6:00 p.m. Pacific Time, Monday through Friday.

How do I get a provider directory?

A current listing of providers can be found under "DocSearch" which is located on the far right side of Health Net's home page. This page my be accessed at: http://www.healthnet.com/raytheon. Printed directories are also available upon request, however the web site provides the most current information available.

How do I order additional ID cards?

You may contact Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695 or submit the request via email to our Internet Response Team at: Raytheon_Inquiries@health.net.

Do I need to carry my ID card with me at all times?

It is best to carry your ID card at all times, if possible, in case an emergency arises.

What do I do in case of an emergency?

In an emergency situation, you may either call 911 or go directly to the nearest hospital.

TRAVEL COVERAGE

What do I do if I need care while traveling?

HMO Level — While out of your medical group's service area, you are covered for emergency and urgently needed care. You may seek services from the nearest provider and services will be covered as long as they meet emergent/urgently needed care criteria. OON Level — Your plan enables you to access covered services at the out-of-network benefit level. You may contact Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695 to request a travel kit. Travel kits include a member claim form to submit to Health Net for reimbursement, as well as information that advises what to do if an emergency situation arises. Claim forms can be obtained at: https://www.healthnet.com/members/forms/default.asp. Please refer to your Evidence of Coverage/Certificate of Insurance for plan specifics.

What routine coverage do I have while I am traveling?

HMO Level — While traveling, coverage is limited to emergency and urgently needed care only. Routine care is not covered under this plan during travel. OON Level — You are covered for routine care while traveling if you seek services with an out-of-network provider. You would be subject to any applicable copayment, coinsurance, or deductibles as outlined in your Evidence of Coverage/Certificate of Insurance .

What emergency coverage do I have while I am traveling?

You are covered for emergency care while traveling and services will always be covered at the highest level of benefits. Please refer to your Evidence of Coverage/Certificate of Insurance for detailed information regarding your specific benefit plan.

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What happens to my coverage if I move out of the area?

If you are enrolled in an HMO or POS plan and move out of the Health Net service area, your coverage will be terminated. You must notify your employer group should an address change occur.

What happens to my coverage if I quit my job or I'm laid off or fired?

Members are eligible for one of the following:

COBRA
Many employer groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please check with your employer to determine if you are eligible.

60+ Continuation Coverage
Many employees who exhaust their federal COBRA or Cal-COBRA coverage may be eligible for continued coverage when all of the following conditions have been met:

- COBRA or Cal-COBRA has been elected and exhausted.
- The former employee was age 60 or older at the time of the original COBRA qualifying event.
- The former employee had worked for the employer for at least 5 years immediately prior to qualifying for COBRA.
- The individual has not yet reached age 65.
- The individual is not yet entitled to Medicare.
- The individual is not covered by another group health plan.

Conversion Coverage
Except as specified below, if you lose coverage in this plan, you may elect coverage through the Health Net conversion plan. Members are responsible for the cost of conversion coverage Please note, however, that the benefits, as well as the premiums, will not be the same as coverage through your group plan.

Who is not eligible for Conversion Coverage?

- (HMO only) Anyone who lives outside the continental United States and who does not either live or work inside the Health Net service area.
- Anyone whose coverage was terminated for cause as stated in the member's Evidence of Coverage/ Certificate of Insurance.
- Anyone who is covered by another group or individual health plan.
- Anyone who was not covered under a Health Net plan when coverage ends.

What happens to my coverage if I retire?

If you retire before your 65th birthday, you may enroll in your employer's early retiree plan.

What if I become disabled?

If you become "totally disabled" as defined by Health Net, your benefits will continue as long as you remain an active employee and are still enrolled in your medical plan. If you become "totally disabled" as defined by Health Net, and you lose your coverage because the group agreement between Health Net or Health Net Life and your employer was terminated, you may be eligible for an extension of benefits. If you become "totally disabled" and lose your health coverage for reasons other than that listed above, or for "termination for cause," then you may be eligible for conversion coverage or COBRA coverage. Please check with your employer to determine if you are eligible.

What if my spouse and I divorce?

If you are covered under a Health Net plan as a spouse and divorce a Health Net subscriber, your coverage will terminate.

Is my child covered while in college?

Enrolled dependents who attend college are eligible for coverage. HMO members who attend college outside the Health Net service area are covered for emergency and urgently needed care only. Health Net may request certification of full-time student status on dependents who are over the age requirements of the employer group. Please refer to your Health Net Evidence of Coverage / Certificate of Insurance for plan specifics.

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Do I have coverage for pre-existing conditions?

Under HMO and POS plans, no pre-existing limitations exist.

What is the Consolidated Omnibus Budget Reconciliation Act (COBRA) and who is eligible?

COBRA is a federal law that requires most employers to provide continuation of group health plan coverage identical to that currently being provided to active employees without any lapse in coverage. Members are eligible for continued coverage when a qualifying event occurs. Examples of qualifying events include: termination of the subscriber's employment, divorce or legal separation from the subscriber, loss of eligibility for a dependent child, death of the subscriber.

What is PCC (Prior Coverage Certification)?

Federal legislation very specifically intends for Health Insurance Portability and Accountability Act of 1996 (HIPAA) Prior Coverage Certificates to be used to credit Health Net covered months against the next carrier's pre-existing condition limit, if any.

What types of provider transfers are available?

You may request a primary care physician transfer within the same medical group on a monthly basis. Effective dates vary depending on the last date of service with your current primary care physician. You may change your physician group during your employer's open enrollment period or when you move to a new address, or you may contact Health Net to request a monthly physician group transfer.

What is a Monthly Physician Group Transfer?

As long as you meet the monthly physician group criteria, and we receive your request for a transfer on or before the 15th day of the current month, the transfer will become effective on the first day of the following month. Any transfer request received after the 15th of the current month would be processed with an effective date of the 1st of the month following the upcoming month. (For example: a transfer requested January 16th has an effective date of March 1st.) Exception: When the 15th falls on a weekend or holiday and the member calls the next business day, the transfer may still be effective the first of the upcoming month.

Can my newborn have his/her own pediatrician?

Based on the effective date of the newborn, most newborns are enrolled in the plan effective the 1st of the month following the date of birth. The newborn would need to see a physician in the mother's current physician group until the first of the month following the release date from the hospital. At that time, he or she can be assigned to a different physician group than the mother. Please contact Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695 for more information or to change the newborn's physician group.

How do I obtain medical care through Health Net?

First, you and your family select a physician group from our Directory of Participating Physician Groups. Each member of your family may choose a different physician group. Then, from your chosen physician group(s), select a Primary Care Physician for each member of your family.

Once you have selected a medical group and Primary Care Physician, obtaining medical care is as simple as making an appointment with that doctor. Your Primary Care Physician becomes the expert on your health history and is responsible for authorizing or delivering all of your medical care.

What if I need to be referred to a specialist?

Health Net offers a service called Rapid Access® that lets you know if you can use self-referral or direct referral (from your Primary Care Physician without physician group authorization) to see a specialist within your medical group for consultation. Check your Directory of Participating Physician Groups or with your physician group for more information. In addition, your Primary Care Physician is responsible for evaluating your case and arranging the most appropriate care for you. If there isn't an appropriate specialist on staff at your physician group, your Primary Care Physician will arrange for you to see an outside physician.

What should I do if I receive a bill for medical care?

Since your care is generally provided on a prepaid basis under your HMO plan, you should not receive bills for routine care. However, if you do receive a bill for care, contact the Health Net Coordinator at your physician group immediately. As long as the care you received was authorized by your physician group and is a covered benefit, you will only be responsible for any copayment for the service rendered.

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How can I cover my newborn from birth?

A newborn child of the subscriber or spouse is eligible for coverage at the moment of birth. Coverage begins automatically and will continue through the 30th day of the newborn child's life without an enrollment taking place. In order for coverage to continue beyond the 30th day of life, the subscriber must enroll the newborn child through the employer before the 30th day of the child's life. If the mother is an enrolled member, the child will be assigned to the mother's selected physician group. If the mother is not an enrolled member, the child will be assigned to the subscriber's selected physician group.

How do I obtain coverage for my new adopted child?

A newly adopted child becomes eligible on the date the birth parent or appropriate legal authority grants, in writing, the subscriber or spouse the right to control the child's health care. Coverage begins automatically and will continue for 30 days from the date of eligibility. Upon enrollment, the child will be assigned to the subscriber's selected physician group. The child must be enrolled before the 30th day in order for coverage to continue beyond the first 30 days. Health Net will require written proof of the right to control the child's health care, signed by a judge, when such child is enrolled.

How do I add or delete family members?

Please contact your employer to add or delete family members from your policy.

Can I cover a dependent who lives out-of-state or my child away at school?

Dependents who reside outside the Health Net service area are ineligible for coverage under HMO/POS plans unless the dependent child has a mandated Medical Child Support Order. Enrolled dependent children who temporarily reside outside the Health Net service area due to schooling or a court order can remain on the plan, but HMO coverage is limited to emergency or urgently needed care.

How often can I change benefit plans?

You may elect to change your benefit plan during your employer's open enrollment period.

How long can my children remain covered?

Coverage for dependent children will continue until one of the following conditions occur: the subscriber becomes ineligible, your employer's specified age limitation for dependent children is reached, the child ceases to meet the full-time student status or is no longer 50% dependent on the parents for economic support, a court order declares the child a legally emancipated minor, marriage, or ceasing to reside in the continental United States. Please refer to your Health Net Evidence of Coverage/Certificate of Insurance for your specific plan's requirements.

How long can my child be covered if he or she has disabilities?

Coverage may continue if your enrolled, unmarried, dependent child becomes incapable of holding a self-sustaining job due to a certified disability. Health Net's determination of eligibility shall be conclusive and disability certification is required. Please refer to your Health Net Evidence of Coverage/Certificate of Insurance for your plan's specific requirements.

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How do I find a network provider?

A current listing of providers can be found under "DocSearch", which is located on the far right side of Health Net's home page. This information can be found at: http://www.healthnet.com/raytheon. Directories are also available upon request, however the website provides the most current information available. You may also contact Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695.

What is a Primary Care Physician?

A Primary Care Physician (PCP) is a member physician who is responsible for coordinating the delivery of covered services and benefits to the member. PCPs include general and family practitioners, internists, pediatricians and obstetrics/gynecologists.

What are the advantages of using network providers?

Members benefit by sharing the cost savings when using a network provider with whom Health Net has discounted contract agreements.

What happens if my current physician is not a network provider?

HMO Level — When enrolling in Health Net, you choose a physician group that uses a network of contracted providers and you must choose a provider within that network. As long as services are authorized by your selected physician group, you will be covered according to your specific benefit plan. Please refer to your Evidence of Coverage/Certificate of Insurance for more details. OON Level — Services will be covered according to your specific benefit plan. Please refer to your Evidence of Coverage/Certificate of Insurance for more details.

How do I change my Primary Care Physician?

You may contact a customer service representative at Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695. You may also email the Internet Response Team to request a Primary Care Physician transfer.

Can I change my Primary Care Physician any time I want?

You may request a Primary Care Physician transfer within the same medical group on a monthly basis. Effective dates vary depending on the last date of service with the current Primary Care Physician.

What if a Primary Care Physician cannot see me right away?

HMO Level — Most physician groups will have another physician on staff if your Primary Care Physician is unavailable. Please contact your Primary Care Physician's office for direction in seeking care. Some medical groups have urgent care facilities that may be available after regular business hours. OON Level — Should your Primary Care Physician be unavailable, you have the option to seek services from an out-of-network physician and pay the applicable copayment, coinsurance, or deductible.

What if a network provider isn't available to treat my condition?

HMO Level — Physician groups may also contract with outside providers. As long as services are determined to be medically necessary and authorized by your selected physician group, you may utilize a non-network provider. OON Level — Services are covered according to your specific benefit plan.

Can I go to a non-network provider?

HMO level — Physician groups may also contract with outside providers. As long as services are determined to be medically necessary and authorized by your selected physician group, you may utilize a non-network provider. OON level — Services are covered according to your specific benefit plan.

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APPROVALS & REFERRALS

What services require prior approval or a referral?

Under HMO plans, the Primary Care Physician (PCP) will request authorization or referral from the member's selected physician group when medically necessary. Under the POS plan, the OON level has a specific list of services that require precertification. Please refer to your Health Net Evidence of Coverage/ Certificate of Insurance for plan specifics.

How do I get prior approval or a referral?

Under HMO plans the Primary Care Physician (PCP) will submit for prior authorization to the member's selected physician group. Under the OON level on POS plans, members are responsible for obtaining prior authorization on specified services through Health Net's Treatment Review Department. This toll-free telephone number is located on the back of your Health Net ID card.

What if I don't get prior approval or a referral?

Under HMO plans, without pre-authorization, the member may be held responsible for the cost of the service. Under the OON level on POS plans, if precertification is not acquired then benefits may be reduced and a penalty may apply wherein you may have a higher out-of-pocket expense. Please refer to your Health Net Evidence of Coverage/Certificate of Insurance for plan specifics.

When do I need a referral from my PCP?

Under HMO plans, the member's Primary Care Physician (PCP) will work with the patient to determine whether a specialist referral is medically indicated. Under the OON level on POS plans, members do not require referrals and may obtain services directly from a specialist.

PHARMACY

How do I obtain coverage for prescription drugs?

Your outpatient prescription drug coverage is not provided through Health Net. Raytheon members should contact Medco at 1-800-864-1431, the company providing outpatient prescription drug coverage, to obtain coverage information.

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How do I file a claim?

HMO level — Members should not have to submit claims for any services received unless services were received prior to being added onto the Health Net system. If this happens, and the member paid out-of-pocket expenses, a claim can be submitted to your selected physician group for any charges incurred while the member was actively enrolled. As long as the care you received was authorized by your physician group and is a covered benefit, you will only be responsible for any copayment for the service rendered. You may contact Health Net directly for the correct address to submit a claim. POS level — Services rendered from an OON provider should be billed directly to Health Net. If you paid out of pocket for services and need to seek reimbursement, simply send Health Net a copy of your receipt or proof of payment (i.e. cancelled check, credit card statement) along with a copy of the claim to: Health Net SELECT Health Plan Operations, PO Box 14702, Lexington, KY 40512.

How long do I have to file a claim?

It is best to file claims within 60 days from the date of service.

A provider has billed me; how do I know how much of the bill to pay?

Please refer to your Evidence of Coverage/Certificate of Insurance for specific plan copayments or coinsurance. Moreover, when Health Net processes a claim, an Explanation of Benefits is generated, which will be mailed to you and the provider and would reflect your financial responsibility. This amount should be remitted to the provider of service.

How can I check the status of my claim?

You may contact Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695. A representative can assist you in providing detailed claim information.

What is the difference between deductibles and copayments?

A deductible is a specified amount a member must pay each calendar year before Health Net will make any benefit payments for eligible services. Copayments are a specified dollar amount that a member must pay out of pocket for a specified service at the time the service is rendered. Both deductibles and copayments vary by plan. Please refer to your Evidence of Coverage/Certificate of Insurance for your specific plan requirements.

How does my out-of-pocket maximum work?

Out-of-pocket maximum (OOPM) and maximum copayment liability (MCL) refer to the maximum dollar amount of covered expenses you are responsible for per calendar year. The OOPM and MCL are an accumulation of coinsurance and copayment amounts. After the maximum is reached, Health Net will pay 100% of covered expenses incurred during the remainder of the calendar year. Certain expenses are not applicable to the OOPM and MCL. Please refer to your Evidence of Coverage/Certificate of Insurance for plan specifics.

Why did I receive a Coordination of Benefit questionnaire and do I have to return it?

Questionnaires are generated when a claim is filed for a dependent in order to determine which health insurance is primary and if other health insurance coverage exists. Yes, it is necessary to return the questionnaire.

What do I do with a foreign medical bill for care I received outside of the U.S.?

You will need to submit a completed member claim form and itemized statement of services to Health Net for review within 90 days from the date of service. The statement should be translated into English and include the following: provider's name and address, date(s) of service, description of treatment, emergency room report (if available), diagnosis and the charges for each service rendered. Also, send in proof of payment (copy of canceled check, credit card receipt, etc). Be sure to keep copies of your records.

What do I do with my AFP bill?

California does not bill insurance companies for the Alpha-Feto Protein (AFP) test, so HMO members should submit the claim directly to their selected physician group, which will process the claim and send payment directly to the state. POS members using their OON level of benefits should submit the claim to Health Net at the address listed on the back of their ID card.

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What is an office visit?

An office visit is when a physician, physician's assistant or nurse practitioner sees you or a family member in the office at your selected medical group. Office visits are covered on all plans. Please refer to your Evidence of Coverage/Certificate of Insurance for any applicable copayments or coinsurance.

What is a specialist consultation?

A specialist is defined as a board-certified physician in a surgical specialty or in an internal medicine, pediatric or other sub-specialty that generally does not function as a Primary Care Physician. Specialist consultations may require a copayment. Please refer to your Evidence of Coverage/Certificate of Insurance for any applicable copayments or coinsurance.

What is home health care?

Home health care services are usually provided to members in their place of residence. They may include, but are not limited to, skilled nursing services provided by a registered nurse or licensed vocational nurse; home health aide services; physical, occupational, speech and respiratory therapy services; and medical social services. These are subject to the conditions and limitations of your specific benefit plan as well as any applicable copayments or coinsurance. Please refer to your Evidence of Coverage/Certificate of Insurance for plan specifics.

What is a vision and hearing exam?

A vision examination is an examination of the eyes, including refractions for the diagnosis or correction of vision. A hearing examination is an examination of the ears, including audiometric examinations for the diagnosis or correction of hearing. Please refer to your Evidence of Coverage/Certificate of Insurance to determine if your plan requires a copayment for vision and hearing examinations.

Are vision exams covered?

Vision examinations are covered through your selected medical group. Coverage includes eye refractions and examinations for the diagnosis or correction of vision, prescriptions for corrective lenses, and fitting of contact lenses. Please refer to your Evidence of Coverage/Certification of Insurance for any applicable copayments or coinsurance.

What is covered under a well-woman exam?

Covered services for a well-woman exam include a medical history and diagnosis, physical examination (with breast and pelvic exams), and Pap smear. Please refer to your Evidence of Coverage/Certificate of Insurance for any applicable copayments or coinsurance.

What is the "age category" on a mammogram?

The age category on a mammogram (for screening purposes in women at low risk of breast cancer) is limited to one baseline low dose mammogram for women between the ages of 35 and 39; one every two calendar years for women between the ages of 40 and 49; and one each calendar year for women age 50 and above.

What are diabetic supplies?

Diabetic supplies are medical equipment and supplies for the management and treatment of diabetes. Diabetic supplies may include, but are not limited to, blood glucose monitors and testing strips, insulin pumps and supplies, lancets and lancet puncture devices, and insulin syringes. Coverage of diabetic supplies will be provided through the durable medical equipment (DME) benefit. Please refer to your Evidence of Coverage/Certificate of Insurance to determine any appropriate copayments or coinsurance.

What is maternity care and family planning?

Maternity care includes hospital and professional services for conditions of pregnancy, prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered. Family planning includes counseling for birth control, infertility treatment, artificial insemination and sterilization. Please refer to your Evidence of Coverage/Certificate of Insurance for specific plan provisions or exclusions as well as any applicable copayments, coinsurance or deductibles.

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What are X-ray and laboratory procedures?

Diagnostic X-ray and laboratory procedures performed in an office or in a hospital setting are covered benefits on all Health Net plans. Please refer to your Evidence of Coverage/Certificate of Insurance to determine if your plan requires a copayment or coinsurance for X-ray or laboratory procedures.

What is the difference between periodic health evaluations and routine physical exams?

Periodic health evaluations are covered on all Health Net plans. Routine physical exams are not covered. Routine physical exams are at times required for insurance, licensing, employment, school, camp or other nonpreventive purposes. Health Net emphasizes preventive care, therefore a periodic health evaluation and diagnostic preventive procedures, for preventive health purposes, are covered. Diagnostic preventive procedures are recommended by the U.S. Preventive Services Task Force. They include, but are not limited to: female breast and pelvic exams, pap smears, blood pressure checks, periodic checkups, routine preventive care, newborn care, office visits and well-baby care.

What are "all other injections"?

Any medically necessary injectable medication administered by a physician, physician assistant or nurse practitioner, and self-injected medications for the treatment of an illness or injury.

Are hospital and skilled nursing facility services covered?

Hospital and skilled nursing facility services are covered on all Health Net plans. Please refer to your Evidence of Coverage/Certificate of Insurance to determine if your plan requires a copayment for these services and whether your plan has any limits on the number of skilled nursing facility days.

What is emergency or urgently needed care?

Health Net defines an emergency as a sudden injury or illness that could threaten life, limb or internal organs. Urgently needed care is defined as immediate treatment for a sudden injury or illness that is required to prevent serious health deterioration. Emergency and urgently needed care services may require a copayment. Please refer to your Evidence of Coverage/Certificate of Insurance to determine if your plan requires a copayment for these services.

What is rehabilitation therapy?

The purpose of rehabilitation therapy is to provide treatment for an injury or illness with the aim of restoring physical abilities. Rehabilitation therapy (physical therapy, speech therapy, occupational therapy and respiratory therapy) is covered after an acute illness or injury or an acute exacerbation of either. Coverage of continuation of rehabilitation is based on continuous functional improvement in response to the treatment plan. Rehabilitation services are deemed to be no longer medically necessary when there is objective evidence that the patient has not demonstrated continuous functional improvement in response to the treatment plan. Please refer to your Evidence of Coverage/Certificate of Insurance to determine if your plan requires a copayment for these services.

Are mental health and substance abuse care covered?

Mental health and substance abuse care is covered. Please refer to your Evidence of Coverage/Certificate of Insurance for any applicable copayments or coinsurance and/or limitations or exclusions.

Can I self-refer to an OB/GYN? (Do I need a PCP referral)?

HMO female members may obtain OB/GYN physician services without first contacting their Primary Care Physician (PCP) as long as the OB/GYN is affiliated with the member's selected physician group.

Do I need a referral to a specialist?

HMO members can obtain a referral to a specialist from their Primary Care Physician (PCP) as long as it is authorized by their selected physician group. POS members using the OON level can obtain services directly with any specialist without a referral.

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BENEFITS (continued)

Do I need a referral to obtain chiropractic or acupuncture services?

Health Net members do not need a referral to receive chiropractic or acupuncture treatment from a participating chiropractor or acupuncturist. Health Net contracts with American Specialty Health (ASH) Plans, California's first and largest specialty health plan for chiropractic and acupuncture benefit programs, to provide acupuncture and chiropractic services to its members. Members may call ASH Plans directly at 1-800-678-9133 or visit www.ashplans.com to find a practitioner close to them. They then contact the practitioner directly to make an appointment for treatment.

What is MHN and who can obtain its services?

Members utilizing their HMO level of benefits are covered for mental health and substance abuse care through Managed Health Network (MHN). MHN is one of the largest providers of quality behavioral health care in the country and is licensed by the California Department of Managed Care. MHN is available 24 hours a day, seven days a week, and services with an MHN contracted provider can be obtained without a referral from the member's Primary Care Physician. If your mental health and substance abuse benefits are administered through MHN, you can locate the MHN phone number on the back of your Health Net ID card.

GRIEVANCES

What is the procedure for lodging a complaint against a provider?

Complaints are received via mail, telephone, fax or email and are investigated by and reported to our Quality Improvement department for corrective action. If appropriate, our Credentialing department is also notified for review during contract renewal time.

How do I appeal a certification or authorization denial?

You may contact a customer service representative at Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695 or send an email to our Appeals and Grievances Department at: https://www.healthnet.com/members/complaints/. You may also fax your inquiry to (818) 676-6802 or mail it to P.O. Box 10348, Van Nuys, CA 91410-0348.

How do I appeal a claim payment or denial?

You may contact Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695 or send an email to our Internet Response Team at: https://www.healthnet.com /members/memail/. You may also fax your inquiry to Health Net's Appeals and Grievance department at (818) 676-6802 or by mailing to P.O. Box 10348, Van Nuys, Ca. 91410-0348.

What if waiting for you to decide on my appeal would harm my health?

Health Net makes every effort to process the member's grievances as quickly as possible. In some cases, members have the right to an expedited review when a delay in the decision-making might pose an imminent and serious threat to the member's health, including but not limited to potential loss of life, limb or major bodily function. In order to expedite your grievance, you may contact our Customer Service Department by using the toll-free telephone number located on your ID card. Health Net will evaluate your request and the member's medical condition to determine if the member's request qualifies for an expedited review. If so, the request will be processed within the 72 hours. If not, the member's grievance will be processed within the standard 30-day time frame.

My Explanation of Benefits says I received services that I did not have. What should I do?

You may contact Health Net's dedicated Member Services line for Raytheon employees at 1-800-628-2695 or send an email to our Appeals and Grievances Department at: https://www.healthnet.com/members/complaints/. You may also fax your inquiry to: (818) 676-6802 or mail it to P.O. Box 10348, Van Nuys, CA 91410-0348. We will then contact our Program Integrity department for further investigation.

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