

# PPO SUMMARY OF BENEFITS

## **INDIVIDUAL & FAMILY PLANS** **Health coverage made easy.**

Effective January 1, 2006



**Health Net**<sup>®</sup>  
A Better Decision

# HEALTH NET PPO PLANS

## PPO COVERAGE CERTIFICATION REQUIREMENTS

We work with you and your doctor to determine the most effective course of treatment covered under your policy. Through our Certification Program, you get approval for coverage before obtaining certain types of services. This helps protect you from undergoing unnecessary medical procedures – and from having to pay a medical bill because a service isn't covered.

When you receive certification for coverage, it means we've determined that the procedure your doctor has recommended is medically necessary and is appropriate treatment for your health problem. Certification also confirms that we'll extend coverage for the procedure, according to the terms of your policy. If you don't obtain certification when it is required, any benefits payable will be reduced by 50 percent. The reduction in benefits by 50 percent will apply to the following procedures:

1. Inpatient admissions. Any type of facility, including but not limited to:
  - Hospital
  - Skilled nursing facility
  - Mental health facility
  - Chemical dependency facility
  - Acute rehabilitation center
  - Hospice
2. Ambulance
  - Air Ambulance
  - Non-emergent transport
3. Ambulatory services
  - Durable Medical Equipment
  - Home Health Care Agency Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy, Hospice Care, tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor) and home uterine monitoring.
  - Prosthesis for major limbs
4. Experimental services, new technology and evolutionary changes in proven technology.
5. Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function).
6. Outpatient Diagnostic Imaging:
  - CT Scans
  - MRA (Magnetic Resonance Angiography)
  - MRI (Magnetic Resonance Imaging)
  - MUGA Cardiac Scan (Multiple Gated Acquisition)
  - PET (Positron Emission Tomography)
  - SPECT (Single Photon Emission Computed Tomography)
7. Surgical procedures including:
  - Abdominal, ventral, umbilical, incisional hernia repair
  - Blepharoplasty
  - Breast reductions and augmentations
  - Mastectomy for gynecomastia
  - Rhinoplasty
  - Sclerotherapy
  - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
8. Temporomandibular Joint (TMJ) Disorder treatment
9. Transplant-related services including pre-evaluation and pre-treatment services, and the transplant procedure.

## CERTIFICATION EXCEPTIONS

Health Net Life (HNL) does not require Certification for dialysis services or maternity care. However, please notify HNL upon initiation of dialysis services or at the time of the first prenatal visit.

We will consider the medical necessity for the proposed treatment, the proposed level of care (inpatient or outpatient) and the duration of the proposed treatment, with the exception of reconstructive surgery incident to a mastectomy.

You must request certification five or more days before the proposed admission date or commencement of treatment, except when due to an emergency. In the event of an emergency, you or your doctor must contact us within 48 hours or as soon as reasonably possible. Services provided as a result of an emergency will not require certification.

*The reduction in benefits by 50 percent that is payable under Individual & Family PPO will continue to apply to benefits payable after you have met your maximum out-of-pocket limit.*

When a member gives birth to a child in a hospital, she is entitled to benefits for 48 hours of inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Certification penalties will not be applied for that period of time. However, certification must be obtained for a cesarean section if the physician determines that a longer stay is medically necessary.

## EXCLUSIONS AND LIMITATIONS

No payment will be made under the Health Net Individual & Family PPO for expenses incurred for, or which are follow-up care to, any of the items below. The following are selective listings only. For comprehensive listings, see the Health Net Life PPO Policy.

- Services and supplies that Health Net Life determine are not medically necessary except as set out under "Does Health Net cover the cost of participation in clinical trials" and "What if I have a disagreement with Health Net?"
- Custodial care. Custodial care is not rehabilitative care and is primarily provided to assist a patient in meeting the activities of daily living, such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net Life determines to be experimental or investigational except as set out under "Does Health Net cover the cost of participation in clinical trials" and "What if I have a disagreement with Health Net?"
- Services or supplies provided before the effective date of coverage, and services or supplies provided after coverage through this plan has ended, are not covered.
- Reimbursement for services for which the Member is not legally obligated to pay the provider or for which the provider pays no charge.

- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to collection, storage or purchase of sperm or ova.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs, and are only covered when a contracted physician performs a fitting examination and in the case of diaphragms and cervical caps, prescribes the device. IUDs are only available through the contracted physician's office, are covered as a medical benefit, and are limited to one fitting and device per year, unless additional fittings or devices are medically necessary. Diaphragms and cervical caps are only available through a prescription from a pharmacy and are limited to one prescription per year unless additional fittings or devices are medically necessary. Injectable contraceptives are covered as a medical benefit when administered by a physician.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body to improve appearance.<sup>1</sup>
- Dental care.<sup>2</sup>
- Treatment and services for temporomandibular joint (TMJ) disorders are covered when determined to be medically necessary, excluding crowns, inlays, bridgework and appliances.
- This Plan only covers services or supplies provided by a legally operated Hospital, Medicare-approved Skilled Nursing Facility, or other properly licensed facility specified as in the Policy. Any institution that is primarily a place for the aged, a nursing home or a similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to recent trauma or the existence of tumors or neoplasms, or when otherwise medically necessary.
- Hearing aids.
- Treatment for mental disorders as a condition of parole or probation and court-ordered testing.
- Private duty nursing.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the Member's treating physician and authorized by Health Net Life.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses.<sup>2</sup>
- Services to reverse voluntary surgically induced infertility.
- Sex change procedures or treatment.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover Medically Necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).
- Physical exams for insurance, licensing, employment, school or camp. Any physical, vision or hearing exams that are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Health Net Life Policy.
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net Life Policy.
- Services for a surrogate pregnancy are covered. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this Plan covers Durable Medical Equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment, jacuzzis and spas; (c) surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions; and (d) stockings, corrective shoes and arch supports.
- Personal or comfort items.
- Disposable supplies for home use.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Physicians treating immediate family members.
- Treatment for alcoholism or drug addiction, except detoxification.
- Conditions caused by the member's commission (or attempted commission) of a felony.
- Conditions caused by release of nuclear energy, when government funds are available.
- Outpatient speech therapy that is not provided in relation to surgery, injury or disease.
- Amounts charged by out-of-network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense.
- Optometric services, eye exercises including orthoptics, except as specifically stated elsewhere in the Policy.
- Services or supplies received for the treatment of a pre-existing condition during the first six consecutive months during which the member is covered.
- Immunizations or inoculations for adults or children, except as described in the Policy.
- Any services not related to the diagnosis or treatment of a covered illness or injury.
- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility primarily for diagnostic tests that could have been performed safely on an outpatient basis.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.
- Expenses in excess of a hospital's (or other inpatient facility's) most common semi-private room rate.
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the member's residence to accommodate the member's physical or medical condition, including the installation of elevators; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy.
- Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity, as determined by Health Net Life.

*(continued)*

<sup>1</sup> When a medically necessary mastectomy has been performed, breast reconstruction surgery and surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast are covered. In addition, when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following: improve function or create a normal appearance to the extent possible, unless the surgery offers a minimal improvement in the appearance of the member.

<sup>2</sup> The PPO ValueChoice Plus, SimpleChoice Plus, SimpleChoice HSA Plus, SmartChoice HSA Plus, FirstChoice PPO Plus and SimpleValue Plus plans include certain dental and vision services as described in this guide. For dental and vision benefit information for these plans, refer to the Dental and Vision insert in this packet.

**OVERVIEW OF INDIVIDUAL & FAMILY PPO COVERAGE OPTIONS THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE**

BENEFIT DESCRIPTION
<b>Lifetime maximum</b>
<b>Annual deductible</b> Family deductible is met when two family members meet their individual deductibles
<b>Annual FirstChoice Dollars<sup>10</sup></b>
<b>Annual out-of-pocket maximum</b> Preferred providers
Non-preferred providers
Visit to physician
X-ray and laboratory procedures <sup>7</sup>
<b>Annual Routine Physical Exams<sup>3</sup></b>
<b>Preventive care</b> Adult preventive care (age 19 and older) Yearly OB/GYN exam <sup>4</sup> (breast and pelvic exams, Pap smears and mammography) / Yearly prostate cancer screening and exam
Child preventive care (newborns to age 18) Checkups, immunizations, vision and hearing exams
<b>Maternity and pregnancy</b> Prenatal and postnatal office visits
Maternity care in hospital
<b>Emergency and urgent care</b> Emergency room (professional and facility charges)
Urgent care center (facility charges)
Ambulance <sup>7</sup>
<b>Outpatient Services<sup>7</sup></b> Outpatient Surgery (hospital or outpatient surgery center charges only)
Outpatient facility services
<b>Hospitalization Services<sup>7</sup></b> Inpatient, semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental health and substance abuse treatment)
Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting)
<b>Reproductive health</b> Sterilization
<b>Other services</b> Rehabilitative therapy includes physical, speech, occupational, respiratory and cardiac therapy (20 visit maximum per calendar year) <sup>7</sup>
Chiropractic care/Acupuncture (12-visit calendar year maximum/\$20 maximum payable per visit)
Mental health for non-severe conditions <sup>5,6,7</sup>
Durable medical equipment (including foot orthotics) <sup>7</sup>
<b>Outpatient prescription drugs<sup>9</sup></b> Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies
<b>Optional Dental &amp; Vision coverage</b>
<b>Dental &amp; Vision Benefits<sup>13,14</sup></b>

ValueChoice 1500	
In-network <sup>1</sup>	Out-of-network <sup>2</sup>
\$6 million	
\$1,500 Subscriber only	
N/A	
\$4,000 single combined in- and out-of-network (includes deductible)	
\$4,000 single combined in- and out-of-network (includes deductible)	
Covered in full after out-of-pocket maximum is met	
Covered in full after out-of-pocket maximum is met	
Not covered	
25%	Not covered
25%	Not covered
Not covered	
Not covered	
25%	
25%	
25%	
25%	50% <sup>8</sup>
25%	50% <sup>8</sup>
25%	50% <sup>8</sup>
25%	50%
25%	Not covered
Covered in full after out-of-pocket maximum is met	
Not covered	
25% inpatient/Covered in full after out-of-pocket maximum is met, outpatient	50% inpatient / Not covered outpatient
50%	Not covered
\$15 Level I (generic)	Not covered
Included with Plus Plans, <sup>15</sup> additional premium required, refer to the rate guide	
For coverage details, refer to the Dental & Vision Insert	

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE POLICY**

<b>ValueChoice 1500</b>	
<b>In-network<sup>1</sup></b>	<b>Out-of-network<sup>2</sup></b>
\$6 million	
\$1,500 Subscriber only	
N/A	
\$4,000 single combined in- and out-of-network (includes deductible)	
\$4,000 single combined in- and out-of-network (includes deductible)	
Covered in full after out-of-pocket maximum is met	
Covered in full after out-of-pocket maximum is met	
Not covered	
25%	Not covered
25%	Not covered
Not covered	
Not covered	
25%	
25%	
25%	
25%	50% <sup>8</sup>
25%	50% <sup>8</sup>
25%	50% <sup>8</sup>
25%	50%
25%	Not covered
Covered in full after out-of-pocket maximum is met	
Not covered	
25% inpatient/Covered in full after out-of-pocket maximum is met, outpatient	50% inpatient / Not covered outpatient
50%	Not covered
\$15 Level I (generic)	Not covered
Included with Plus Plans, <sup>15</sup> additional premium required, refer to the rate guide	
For coverage details, refer to the Dental & Vision Insert	

<b>SimpleChoice HSA</b>	
<b>In-network<sup>1</sup></b>	<b>Out-of-network<sup>2</sup></b>
\$6 million	
\$4,000 single / \$8,000 family All benefits, including Outpatient Prescription Drugs, are subject to the deductible except Preventive Care. For contracts of two or more members, there are no benefits until the family deductible is met.	
N/A	
\$4,000 single / \$8,000 family combined in- and out-of-network (includes deductible)	
\$5,000 single / \$10,000 family combined in- and out-of-network (includes deductible)	
Covered in full after deductible is met	50%
Covered in full after deductible is met	50%
Covered in full after deductible is met	Not covered
\$40 (Deductible waived)	Not covered
\$40 (Deductible waived)	Not covered
Not covered	
Not covered	
Covered in full after deductible is met	
Covered in full after deductible is met	
Covered in full after deductible is met	
Covered in full after deductible is met	50% <sup>8</sup>
Covered in full after deductible is met	50% <sup>8</sup>
Covered in full after deductible is met	50% <sup>8</sup>
Covered in full after deductible is met	50%
Covered in full after deductible is met	Not covered
Covered in full after deductible is met	Not covered
Covered in full after deductible is met	Not covered
Covered in full after deductible is met – inpatient and outpatient	50% inpatient / Not covered outpatient
Covered in full after deductible is met	Not covered
Covered in full after deductible is met	Not covered
Included with Plus Plans, <sup>15</sup> additional premium required, refer to the rate guide	
For coverage details, refer to the Dental & Vision Insert	

**SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

SmartChoice HSA	
In-network <sup>1</sup>	Out-of-network <sup>2</sup>
\$6 million	
\$2,500 single / \$5,000 family All benefits, including Outpatient Prescription Drugs, are subject to the deductible except Preventive Care. For contracts of two or more members, there are no benefits until the family deductible is met.	
N/A	
\$4,000 single / \$10,000 family combined in- and out-of-network (includes deductible)	
\$4,000 single / \$10,000 family combined in- and out-of-network (includes deductible)	
30%	50%
30%	50%
\$70 (deductible waived)	Not covered
\$35 (deductible waived)	Not covered
\$35 (deductible waived)	Not covered
Not covered	
Not covered	
\$70 copay <sup>11</sup> plus 30%	
\$50 copay <sup>11</sup> plus 30%	
30%	
\$250 copay <sup>12</sup> plus 30%	\$250 copay <sup>12</sup> plus 50% <sup>8</sup>
30%	50% <sup>8</sup>
\$250 per admission copay <sup>12</sup> plus 30%	\$250 per admission copay <sup>12</sup> plus 50% <sup>8</sup>
30%	50%
30%	Not covered
30%	50%
50%	Not covered
\$250 per admission copay plus 30% inpatient / 30% outpatient	\$250 per admission copay plus 50% inpatient / Not covered outpatient
50%	Not covered
30%	Not covered
Included with Plus Plans, <sup>15</sup> additional premium required, refer to the rate guide	
For coverage details, refer to the Dental & Vision Insert	

SimpleChoice PPO	
In-network <sup>1</sup>	Out-of-network <sup>2</sup>
\$6 million	
Plan 15: \$1,500, 2 per family Plan 25: \$2,500, 2 per family Plan 35: \$3,500, 2 per family Plan 40: \$4,000, 2 per family Plan 50: \$5,000, 2 per family	
N/A	
Each member must meet calendar year deductible only / 2 per family	
\$10,000 / 2 per family combined in- and out-of-network (includes deductible)	
Covered in full after deductible is met	50%
Covered in full after deductible is met	50%
Covered in full after deductible is met	Not covered
Plan 15: \$15 / Plan 25: \$25 Plan 35: \$35 / Plan 40: \$40 Plan 50: \$50 (Deductible waived)	Not covered
Plan 15: \$15 / Plan 25: \$25 Plan 35: \$35 / Plan 40: \$40 Plan 50: \$50 (Deductible waived)	Not covered
Plans 15, 25, 35, 50: Not covered Plan 40: Covered in full after deductible is met	Plans 15, 25, 35, 50: Not covered Plan 40: 50%
Plans 15, 25, 35, 50: Not covered <b>Plan 40: Covered in full after deductible is met</b>	Plans 15, 25, 35, 50: Not covered <b>Plan 40: 50%<sup>8</sup></b>
Covered in full after deductible is met	
Covered in full after deductible is met	
Covered in full after deductible is met	
Covered in full after deductible is met	50% <sup>8</sup>
Covered in full after deductible is met	50% <sup>8</sup>
Covered in full after deductible is met	50% <sup>8</sup>
Covered in full after deductible is met	50%
Covered in full after deductible is met	Not covered
Covered in full after deductible is met	Not covered
50%	Not covered
Covered in full after deductible is met – inpatient and outpatient	50% inpatient / Not covered outpatient
Covered in full after deductible is met	Not covered
\$5 Level I (generic) \$250 brand deductible \$35 Level II (brand) \$50 Level III (non-formulary)	Not covered
Included with Plus Plans, <sup>15</sup> additional premium required, refer to the rate guide	
For coverage details, refer to the Dental & Vision Insert	

SimpleValue 50	
In-network <sup>1</sup>	Out-of-network <sup>2</sup>
\$6 million	
\$0 Subscriber only	
N/A	
\$7,500 (combined in- and out-of-network)	
\$10,000 (combined in- and out-of-network)	
\$50	50%
50%	50%
50%	Not covered
\$50	Not covered
\$50	Not covered
Not covered	
Not covered	
\$50 copay <sup>11</sup> plus 50%	
50%	
50%	
\$400 copay <sup>12</sup> plus 50%	\$400 copay <sup>12</sup> plus 50% <sup>8</sup>
50%	50% <sup>8</sup>
\$400 copay <sup>12</sup> per day / 4 day maximum plus 50%	\$400 copay <sup>12</sup> per day / 4 day maximum plus 50% <sup>8</sup>
50%	50%
50%	Not covered
50%	50%
50%	Not covered
50% – inpatient and outpatient	50% inpatient / Not covered outpatient
50%	Not covered
<b>Two RX options available:</b> <sup>9,16</sup> <b>1) Combo</b> \$10 Level I (generic) \$750 brand deductible \$35 Level II (brand) \$50 or 50% (whichever is greater) Level III (non-formulary) <b>or 2) Generic Only</b> \$10 Level I (generic)	Not covered
Included with Plus Plans, <sup>15</sup> additional premium required, refer to the rate guide	
For coverage details, refer to the Dental & Vision Insert	

SimpleValue 40	
In-network <sup>1</sup>	Out-of-network <sup>2</sup>
\$6 million	
\$0 Subscriber only	
N/A	
\$7,500 (combined in- and out-of-network)	
\$10,000 (combined in- and out-of-network)	
\$40	50%
40%	50%
40%	Not covered
\$40	Not covered
\$40	Not covered
Not covered	
Not covered	
\$50 copay <sup>11</sup> plus 40%	
40%	
40%	
\$400 copay <sup>12</sup> plus 40%	\$400 copay <sup>12</sup> plus 50% <sup>8</sup>
40%	50% <sup>8</sup>
\$400 copay <sup>12</sup> per day / 4 day maximum plus 40%	\$400 copay <sup>12</sup> per day / 4 day maximum plus 50% <sup>8</sup>
40%	50%
40%	Not covered
40%	50%
40%	Not covered
40% – inpatient and outpatient	50% inpatient / Not covered outpatient
40%	Not covered
<b>Two RX options available:</b> <sup>9,16</sup> <b>1) Combo</b> \$10 Level I (generic) \$750 brand deductible \$35 Level II (brand) \$50 or 50% (whichever is greater) Level III (non-formulary) <b>or 2) Generic Only</b> \$10 Level I (generic)	Not covered
Included with Plus Plans, <sup>15</sup> additional premium required, refer to the rate guide	
For coverage details, refer to the Dental & Vision Insert	





- All benefits provided under the Policy shall be reduced by any amounts to which a member is entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before an individual health plan.
- Services performed by a person who lives in the member's home or who is related to the member by blood or marriage.
- Any services provided by, or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare.
- If the member receives services or obtains supplies in a foreign country, benefits will be payable for emergency care only.
- Hyperkinetic syndromes, learning disabilities, behavior problems or mental retardation, regardless of the type of service. Certain conditions are covered if their level of severity meets the criteria of serious emotional disturbances of a child or severe mental illness.
- Services to diagnose, evaluate or treat infertility.

### PRODUCT-SPECIFIC EXCLUSIONS AND LIMITATIONS

ValueChoice 1500, SimpleChoice 50, SimpleChoice 35, SimpleChoice 25, SimpleChoice 15, SimpleChoice HSA, SmartChoice HSA, FirstChoice PPO, SimpleValue 50, SimpleValue 40 and SimpleValue 30.

- Care for conditions of pregnancy, including hospital and professional services. This includes prenatal and postnatal care, and delivery.

FirstChoice PPO

- Elective Abortions
- Contraceptive Devices
- Chiropractic Care

ValueChoice 1500 and SmartChoice HSA

- Immunizations or inoculations for foreign travel or occupational purposes.

ValueChoice 1500

- Allergy serum
- Routine physical examinations

ValueChoice 1500, SmartChoice HSA and FirstChoice PPO

- Acupuncture

ValueChoice 1500, FirstChoice PPO, SimpleValue 50 with Generic RX, SimpleValue 40 with Generic RX and SimpleValue 30 with Generic RX

- Brand and non-formulary prescription drugs

### For more information, please contact:

Health Net  
Post Office Box 1150  
Rancho Cordova, California 95741-1150

Individual & Family Plans:

**1-800-909-3447**

1-800-331-1777 (Spanish)

1-877-891-9053 (Mandarin)

1-877-891-9050 (Cantonese)

1-877-339-8596 (Korean)

1-877-891-9051 (Tagalog)

1-877-339-8621 (Vietnamese)

Telecommunications Device

for the Hearing and Speech Impaired:

**1-800-995-0852**

**[www.healthnet.com](http://www.healthnet.com)**