

HEALTH NET COMMERCIAL SMALL BUSINESS GROUP
100% HSA PLANS EFFECTIVE 1/1/09*

KEY BENEFITS ¹	HSA 2000		HSA 3000		HSA 4000	
	PPO ²	OON ³	PPO ²	OON ³	PPO ²	OON ³
Deductible and plan maximums						
Calendar Year Deductible	\$2,000 single / \$4,000 family		\$3,000 single / \$6,000 family		\$4,000 single / \$8,000 family	
Out-of-Pocket Maximum	\$2,000 single / \$4,000 family	\$4,000 single / \$8,000 family	\$3,000 single / \$6,000 family	\$8,000 single / \$12,000 family	\$4,000 single / \$8,000 family	\$8,000 single / \$16,000 family
Lifetime Medical Benefit Maximum	\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
Professional services						
Office visit	\$0 copayment (deductible not waived)	50%	\$0 copayment (deductible not waived)	50%	\$0 copayment (deductible not waived)	50%
Preventive Care services for children (through age 18)	\$30 copayment (deductible waived)	Not Covered	\$30 copayment (deductible waived)	Not Covered	\$30 copayment (deductible waived)	Not Covered
Preventive Care services for adults, including Annual Preventive Physicals (age 18 and older)	\$30 copayment (deductible waived)	Not Covered	\$30 copayment (deductible waived)	Not Covered	\$30 copayment (deductible waived)	Not Covered
Specialist consultation	0%	50%	\$20 copayment (deductible not waived)	50%	0%	60%
X-ray and Laboratory procedures ⁴	0%	50%	20%	60%	0%	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	0%	50%	20%	60%	0%	50%
	12 visits per calendar year combined with PPO and OON		12 visits per calendar year combined with PPO and OON		12 visits per calendar year combined with PPO and OON	
Self-injectables Drugs	0%	50%	0%	50%	0%	50%
Hospital services⁴						
Inpatient Hospital Facility Services (includes maternity)	0%	50% (\$600 maximum allowable per day)	0%	50% (\$600 maximum allowable per day)	0%	50% (\$600 maximum allowable per day)
	\$250 deductible per calendar year ⁶		\$250 deductible per calendar year ⁶		\$250 deductible per calendar year ⁶	
Outpatient Services (other than surgery)	0%	50% (50% maximum allowable)	20%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
Outpatient surgery (Hospital or Outpatient Surgical Center charges only)	0%	50% (50% maximum allowable)	20%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
	\$250 Inpatient deductible per calendar year ⁷		\$250 Inpatient deductible per calendar year ⁷		\$250 Inpatient deductible per calendar year ⁷	
Skilled Nursing Facility	0%	50% (\$250 maximum payable per day)	20%	50% (\$250 maximum allowable per day)	30%	50% (\$250 maximum allowable per day)
	\$250 Inpatient deductible per calendar year ⁶		\$250 Inpatient deductible per calendar year ⁶		\$250 Inpatient deductible per calendar year ⁶	
	(90 days per calendar year combined with PPO and OON)		(90 days per calendar year combined with PPO and OON)		(90 days per calendar year combined with PPO and OON)	
Emergency services						
Professional Services	\$0 copayment (deductible not waived)		\$0 copayment (deductible not waived)		\$0 copayment (deductible not waived)	
Emergency Room Facility (copayment waived if admitted)	\$100 copayment + 0%		\$100 copayment + 0%		\$100 copayment + 0%	
Urgent Care Facility	\$50 copayment + 0%		\$50 copayment + 0%		\$50 copayment + 0%	
Ambulance services (Ground and Air) ⁴	\$50 copayment + 0%	\$50 copayment + 0%	\$50 copayment + 0%	\$50 copayment + 0%	\$50 copayment + 0%	\$50 copayment + 0%
Other services						
Durable medical equipment and Orthotics ⁴	0%	50%	0%	50%	0%	50%
	(\$2,000 per calendar year combined with PPO and OON)		(\$2,000 per calendar year combined with PPO and OON)		(\$2,000 per calendar year combined with PPO and OON)	
Diabetic Equipment	0%	50%	0%	50%	0%	50%
Chiropractic Services	\$0 (deductible not waived) (12 visits per calendar year)	Not Covered	\$0 copayment (deductible not waived) (12 visits per calendar year)	Not Covered	\$0 copayment (deductible not waived) (12 visits per calendar year)	Not Covered
Acupuncture	\$0 (deductible not waived)	50%	\$0 (deductible not waived)	50%	\$0 (deductible not waived)	50%
	12 visits per calendar year combined with PPO and OON		12 visits per calendar year combined with PPO and OON		12 visits per calendar year combined with PPO and OON	
	\$25 maximum payable per visit combined with PPO and OON		\$25 maximum payable per visit combined with PPO and OON		\$25 maximum payable per visit combined with PPO and OON	
Prescription drug coverage⁶						
Calendar Year Deductible (per covered person)	Subject to annual deductible		Subject to annual deductible		Subject to annual deductible	
Prescription drugs (up to a 30-day supply)	0%	50%	0%	50%	0%	50%

Footnotes:

- This is a summary of your benefits. It does not include all services, limitations, or exclusions. Please refer to the Policy/Certificate for terms and conditions of coverage.
- Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- Limited Fee Schedule reimbursement is at the 75th percentile of RBRVS. The member is responsible for charges in excess of allowed in addition to the coinsurance shown.
- These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.
- Prescription drugs filled through mail order (up to a 90 day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.
- The deductible is required only for the first inpatient hospital or skilled nursing facility admission each calendar year. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible.
- Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar-year. This deductible is in addition to the plan calendar year deductible.

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