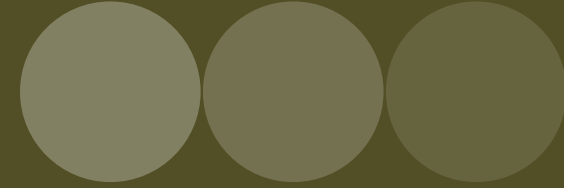


Making smart choices is the key to living well.



NETWORK CHOICES

As a member of Business Health Trust, you can choose from four Group Health Options, Inc. health plans, each offering tools and services designed to keep you feeling your best, easily. Each plan lets you choose care from Group Health Cooperative, Virginia Mason, and The Everett Clinic or contracted community doctors in-network. You can also see licensed physicians out-of-network at a discounted rate through First Choice Health or Beech Street networks, or see any licensed doctor anywhere.

If you see a licensed provider outside of the First Choice network, you may be subject to Usual, Customary and Reasonable (UCR) charges and balance billing may apply.

MYGROUPHEALTH FOR MEMBERS

MyGroupHealth for Members is the online service that makes connecting to your health care easier than ever—and it's yours at no extra charge. Visit www.ghc.org to see why thousands of members use MyGroupHealth to make a stronger connection to their health care.

- Refill prescriptions
- Securely e-mail your doctor*
- View your online medical record*
- Get test results*
- Schedule appointments*
- Create your own Health Profile
- Access your child's records through age 12*
- Work with a lifestyle coach
- Check your benefits

*Service available when you get care at a Group Health medical center.

BHT health plans offered by Group Health Options, Inc.

EFFECTIVE 10/01/09–09/30/10

PLAN BENEFIT	ALLIANT PLUS 200 BALANCE PLAN*		ALLIANT PLUS 500 MID PLAN		ALLIANT PLUS 1000 BALANCE PLAN		ALLIANT PLUS 3000 50/50 PLAN	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
ANNUAL DEDUCTIBLE shared in- and out-of-network	\$200 individual 3x Family waived for all outpatient services		\$500 individual 3x Family waived for all outpatient services		\$1,000 individual 3x Family waived for all outpatient services		\$3,000 individual 3x Family waived for all outpatient services	
COINSURANCE What the plan pays	90%	70%	80%	60%	70%	50%	50%	50%
OUT OF POCKET LIMIT Excludes deductible	\$2,000 individual 3x Family		\$2,000 individual 3x Family		\$3,000 individual 3x Family		\$5,000 individual 3x Family	
EMERGENCY CARE COPAY	\$100, waived if admitted	\$150, waived if admitted	\$100, waived if admitted	\$150, waived if admitted	\$150, waived if admitted	\$200, waived if admitted	\$100, waived if admitted	\$150, waived if admitted
PRESCRIPTION DRUGS Retail (30-day supply)	\$20/\$40	\$25/\$45	\$20/\$40	\$25/\$45	\$20/\$40	\$25/\$45	\$20/\$40	\$25/\$45
Mail order (90-day supply)	2x retail cost share	Not covered	2x retail cost share	Not covered	2x retail cost share	Not covered	2x retail cost share	Not covered
DEDUCTIBLE WAIVED FOR OUTPATIENT SERVICES								
OFFICE VISITS	\$20 copay	\$20 copay	\$20 copay + 20%	\$20 copay + 40%	\$25 copay + 30%	\$25 copay + 50%	50%	50%
PREVENTIVE CARE in accordance w/well-care schedule	\$20 copay	\$20 copay	\$20 copay + 20%	\$20 copay + 40%	\$25 copay + 30%	\$25 copay + 50%	50%	50%
DIAGNOSTIC LAB AND RADIOLOGY Outpatient	Covered in full	Covered in full	20%	40%	30%	50%	50%	50%
ALTERNATIVE CARE Spinal manipulations – 10 visits PCY	\$20 copay	\$20 copay	\$20 copay + 20%	\$20 copay + 40%	\$25 copay + 30%	\$25 copay + 50%	50%	50%
Acupuncture – 8 visits PCY	\$20 copay	\$20 copay	\$20 copay + 20%	\$20 copay + 40%	\$25 copay + 30%	\$25 copay + 50%	50%	50%
REHABILITATION SERVICES Outpatient – limit 60 visits PCY	\$20 copay	\$20 copay	\$20 copay + 20%	\$20 copay + 40%	\$25 copay + 30%	\$25 copay + 50%	50%	50%
CHEMICAL DEPENDENCY Outpatient (max. \$14,500 per any 24 consecutive months)	\$20 copay	\$20 copay	\$20 copay + 20%	\$20 copay + 40%	\$25 copay + 30%	\$25 copay + 50%	50%	50%
MENTAL HEALTH Outpatient – limit 20 visits PCY	\$20 copay	\$20 copay	\$20 copay + 20%	\$20 copay + 40%	\$25 copay + 30%	\$25 copay + 50%	50%	50%
AFTER DEDUCTIBLE, MEMBER PAYS								
DIAGNOSTIC LAB AND RADIOLOGY Inpatient	10%	30%	20%	40%	30%	50%	50%	50%
REHABILITATION SERVICES Inpatient – limit 60 days PCY	10%	30%	20%	40%	30%	50%	50%	50%
CHEMICAL DEPENDENCY Inpatient (max. \$14,500 per any 24 consecutive months)	10%	30%	20%	40%	30%	50%	50%	50%
MENTAL HEALTH Inpatient – limit 12 days PCY	10%	30%	20%	40%	30%	50%	50%	50%

* Deductible and Coinsurance waived for outpatient services
PCY = per calendar year
Lifetime benefit maximum, up to \$500 annual restoration, of \$2 million applies to all plans.

This is a brief summary of benefits. For complete details of benefits and exclusions, please refer to the actual plan certificate of coverage or contract. Should there be any discrepancy the contract will be the determining document on how benefits are paid.

