

Summary of Contract Changes

GROUP NAME: Washington Biotechnology & Biomedical Association
GROUP NUMBER(S): 100000021
RENEWAL DATE: January 1, 2008

Federal ERISA and HIPAA regulations require the Plan Sponsor (the group) to notify employees of material modifications and material reductions to their group health plan. To ensure compliance with these regulations, please provide your employees with any benefit changes listed below.

Sections within this document may require your input or initials; if so, please return a copy of the completed Renewal Letter to your Marketing Coordinator.

Women's Health Act Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Refer to your benefit booklet for more information.

Changes

If the state or federal government mandates any additional change in benefits or if Premera Blue Cross revises benefits or provisions after this renewal is issued, a supplemental notice will be provided.

Your Heritage or Foundation Plus 1 plan is now called *Your Choice*.

Your Global plan is now called *Your World*.

Your Heritage Plus 1 HSA plan is now called *Your Future*.

The following changes will be made at renewal:

Regulatory Directives

The following changes apply to all plans.

Chemical Dependency Maximum

The maximum benefit for chemical dependency treatment in any 24-month period has been raised to \$14,000.

Special Enrollment (Involuntary Loss of Coverage)

We have clarified that if the Group offers more than one plan, and a member reaches the lifetime maximum in one of the other plans, he/she will be offered coverage in this plan if one of two things is true:

- The lifetime maximum of this plan is higher than that of the other plan

- The benefits paid under the other plan could not be credited toward this plan's lifetime maximum. (See *Plan Transfers* in the booklet for credits applied for transfers between two Premera Blue Cross plans.)

TRICARE

Federal law now requires that in most cases the benefits of this plan will be provided on a primary basis to TRICARE beneficiaries. TRICARE beneficiaries are U.S. military personnel (active or retired) or their dependents enrolled in the TRICARE program. We have added references to TRICARE to our *What If I Have Other Coverage?* section and updated the Military And War-Related Conditions exclusion so that it does not exclude TRICARE beneficiaries.

Other Changes That Affect Your Benefits

The following changes apply to all plans unless specific plans are noted.

Deductible Carryover – Applies to PPO and Global Plans

For plans that include a deductible carryover benefit and an out-of-pocket maximum, we have clarified that the expenses from a prior year that are credited to the current year's deductible are not also credited toward the current year's out-of-pocket maximum.

If the deductible carryover benefit is removed, the change will take effect on your plan's renewal date. Starting on that date we will credit expenses applied to the deductible **only** if they were incurred during the current calendar year. We will no longer credit expenses incurred in the fourth quarter of the previous calendar year.

Deductible Carryover – Applies to HSA Plan

If you transfer to this plan from a PBC plan that had a deductible carryover benefit, we will credit expenses applied to the prior plan's deductible **only** if they were incurred during the current calendar year. Starting on the date this plan is effective, we will no longer credit expenses incurred in the fourth quarter of the previous calendar year toward this plan's deductible.

Diagnostic Services- Applies to HSA Plan

The Diagnostic Services benefit has been changed. The plan's calendar year deductible will no longer apply to preventive diagnostic services received from network providers. The calendar year deductible and coinsurance apply to all other diagnostic services. The Diagnostic and Screening Mammography benefit has been changed to match the Diagnostic Services benefit.

We have also clarified that when covered outpatient diagnostic services are billed by an outpatient hospital or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the *Hospital Outpatient or Emergency Room Services* benefits.

Copays For Professional Visits – Applies to Plan D Only

We have made some changes in some benefits' copay structure. Outpatient visits for rehabilitative and chronic pain care, neurodevelopmental therapy, nutritional therapy, chemical dependency treatment and biofeedback (for migraines and other conditions for which biofeedback is not deemed experimental or investigational) are no longer subject to the 4-visit copay limit. The professional visit copay will continue to apply to all visits to network providers.

For the benefits that are subject to the 4-visit limit, professional home and office visits in excess of the first 4 now require only the applicable calendar year deductible and coinsurance.

Diagnostic Services– Applies to Plan D Only

We have simplified the description of members' share of the cost for services covered under the Diagnostic Services benefit. We have also clarified that when covered outpatient diagnostic services are billed by an outpatient hospital or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the *Hospital Outpatient* or *Emergency Room Services* benefits.

How Does Selecting A Provider Affect My Benefits

- The language in the *When You Get Care In Alaska* subsection has been simplified and now refers generically to our “contracted” providers.
- **Applies to Global Plan** -The language describing *When You Get Care In Washington Or Alaska* has been revised. We have clarified that, when you get care in Washington, the *Your World* plan uses our Global provider network. Our Global network is our broadest network, consisting of all of our contracting providers. *Your World* continues to cover non-network providers subject to the same deductible and coinsurance requirements as for Global providers. However, non-network providers can also bill you for amounts above our allowable charge.
- **Applies to All Other Plans** - In the *When You Get Care Outside Washington and Alaska* subsection, the explanation of what “allowable charge” applies for providers outside Washington and Alaska has been revised. If the provider you choose doesn’t have an agreement with the local Blue Cross and/or Blue Shield Licensee, the allowable charge is what our maximum allowance would have been if your care had been furnished by a provider that has an agreement in effect with us.

Medical Equipment

We have revised the list of items not covered by the Medical Equipment and Supplies benefit to include structural enhancements and changes to members homes or cars and to exclude sauna baths, portable whirlpool devices, and massage devices.

Residential Mental Health Care

We have clarified that the plan does not cover residential mental health services.

Obesity Services Exclusion – Applies to HSA Plan

In the *Limited and Non-Covered Services* section, we have clarified that treatment of diabetes covered under the Diabetes Health Education and Nutritional Therapy benefits is not subject to the Obesity Services exclusion.

Obesity Services Exclusion – Applies to All Other Plans

In the *Limited and Non-Covered Services* section, we have clarified that treatment of diabetes covered under the Health Management and Nutritional Therapy benefits is not subject to the Obesity Services exclusion.

Oncology Clinical Trials

A definition of “Oncology Clinical Trials” has been added. Services that meet this definition are no longer excluded from coverage under the Experimental/Investigational Services exclusion.

Non-Network Providers – Applies to HSA Plan

Your plan will no longer have an out-of-pocket maximum limit for services provided by non-network providers.

Prescription Drugs – Applies to PPO and Global Plans

You will see some changes in the Prescription Drugs benefit:

- The *Injectable Supplies* provision has been revised to more clearly indicate that when insulin needles and syringes are purchased along with insulin, only your share of the cost of the insulin will apply. If needles and syringes are purchased with any other injectable drug, the member must pay a separate copay or coinsurance for these items.
- The *Specialty Pharmacy* provision has been moved to question 5 in the pharmacy FAQ and revised to clarify our procedures regarding drugs. Specialty drugs must now be dispensed solely through our specialty pharmacy program. For more details on specialty drugs and our designated specialty pharmacies, please visit our Web site at www.premera.com.
- Your plan now requires the use of generic drugs when available. A prescriber or member may request a brand-name drug instead of a generic, but if a generic equivalent is available, payment of the difference in price between the brand-name drug and the generic equivalent is required in addition to paying the applicable brand-name drug cost share.

Insured and self-funded 200+ groups have the option of not making generic substitution mandatory. Please indicate whether you want this change by checking the “yes” or “no” box below.

| | |
|--------------------------|-----|
| <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | No |

Prescription Drugs – Applies to HSA Plan

If your plan includes a Prescription Drugs benefit, you will see some changes in it:

- The *Specialty Pharmacy* provision has been moved to question 5 in the pharmacy FAQ and revised to clarify our procedures regarding drugs. Specialty drugs must now be dispensed solely through our specialty pharmacy program. For more details on specialty drugs and our designated specialty pharmacies, please visit our Web site at www.premera.com.
- The calendar year deductible and coinsurance is waived for prescription drugs we have determined to be cardiac preventive care prescription drugs.
- We have removed language that required the member to pay an additional cost if a brand-name drug was ordered when a generic equivalent was available and the provider would allow member to take the generic.

Preventive Medical Care – Applies to All Plans

We have clarified that outpatient preventive medical care provided for newborns in the 3-week period specified under the Newborn Care Benefit is now covered under the Preventive Medical Care benefit.

Repair of a Dependent Child’s Congenital Anomaly

Language has been added to the benefits for Surgical Services and Professional Visits to clarify repair of a dependent child’s congenital anomaly is covered. The exclusion for orthognathic surgery in the *What’s Not Covered?* section has been revised to make an exception for repair of a dependent child’s congenital anomaly.

Surgical Services

We have clarified that injections administered in a professional setting, which are not named as covered under other benefits, are covered under the Surgical Services benefit.

Temporomandibular Joint (TMJ) Disorders – Applies to HSA Plan

TMJ coverage is now included as a core benefit. Benefits are provided on the same basis as other services, subject to a calendar year maximum of \$1,000 per member and a lifetime maximum of \$5,000 per member.

Changes That Do Not Affect Your Benefits

The following changes apply to all plans unless specific plans are noted.

Appeals

- We have clarified that any extension of the 60 calendar day limit to submit a Level II appeal request shall in no case exceed 180 days.
- We have clarified the *Level II* appeal section to more clearly state that a Level II request for an independent review must be received within 60 days after the date you receive our Level II decision.

Coinsurance Exceptions

The *What's My Coinsurance?* section of your booklet now lists benefits that are exceptions to the coinsurance standards described.

False or Misleading Statements

We have revised the *Intentionally False Or Misleading Statements* provision in *Other Information About My Plan* to more clearly address fraud and knowingly false or misleading information.

Continuation Under USERRA

A section named "Continuation Under USERRA" has been added in compliance with the Uniformed Services Employment And Reemployment Rights Act (USERRA) that protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service.

Organizational Changes – Applies to PPO and Global Plans

- If your plan includes a Preventive Medical Care benefit, a Prescription Drugs benefit, a Vision benefit, a Hearing benefit, a Dental Care benefit, or an Orthognathic Surgery benefit, this benefit has been moved into a new section called "Special Benefits." Other sections of the booklet that reference these benefits now state that if the plan includes them, descriptions can be found in the Special Benefits section.
- We have revised the discussion of copays and coinsurance in the prescription drug benefit to be more generic.

Organizational Changes – Applies to HSA and Plan D

- If your plan includes a Prescription Drugs benefit or a Vision benefit, this benefit has been moved into a new section called "Special Benefits." Other sections of the booklet that reference these benefits now state that if the plan includes them, descriptions can be found in the Special Benefits section.
- We have revised the discussion of copays and coinsurance in the prescription drug benefit to be more generic.
- **Applies to HSA Plan** - In some benefits, we have simplified the language that describes members' share of the cost of covered services.

Venue

In the *Venue* section, we have added arbitration proceedings to further clarify our subrogation procedures.

What If I Have Other Coverage?

The *Third-Party Liability (Subrogation)* provision and the *Uninsured and Underinsured Motorist Coverage* provision have been renamed and the text has been revised to clarify our subrogation procedures.

Workers Compensation Coverage

In the *What's Not Covered* section, we have added "Worker's Compensation or similar coverage" as an additional item to the list in the *Benefits From Other Sources* exclusion.

Employer Contract Changes

HIPAA Certificates

We have clarified that, in addition to providing a HIPAA certificate automatically at members' termination, we will provide a certificate at the member's request as required by HIPAA. We have also removed a provision that stated that if we did not have all the information needed to complete the certificate, we would forward the certificate information to the Group to complete.

Compliance with Law

- In the *Compliance With Law* provision, we have removed the sentence about the Balanced Budget Act of 1997. In its place, we have added a broader requirement that the Group must comply with applicable laws and regulations governing the treatment and benefits of members that have Medicare.
- We have also specified the Group must provide notifications required by HIPAA to all eligible employees before their enrollment. If the Group uses our member enrollment form, the notice will be included on the form. Groups that enroll members by other means will need to provide the notices separately. Notices are available on our Web site at www.premera.com.

Service Marks

We have reformatted the information about Blue Cross and Blue Shield logos in the *Independent Corporation* provision.

Funding Arrangement Changes

Organizational Changes

- The group numbers on the face page of the funding arrangement have been deleted. These numbers appear on the face page of the employer contract.
- "Enrollees" are now referred to as "Members" and "Contract Period" is now referred to as "Contract Term."
- The definitions of "Contract Period," "Enrollee," "Group," and "Plan" have been removed. The terms "member," "Group," and "plan" are already defined in the benefit booklet that forms a part of the contract. Those definitions apply to the funding arrangement. "Contract Term" is discussed in the "Contract Term and Renewal" section of the employer contract.
- We have added a definition of "Due Date." This term appears on the face page of the employer contract.
- We have removed the explanation of events that result in termination. This explanation appears in the *When Will My Coverage End?* section of the benefit booklet.
- The *Assignment, Trademark, Notice* and *The BlueCard® Program* subsections have been moved from section VII to the employer contract.
- The last paragraph of the funding arrangement, which addressed payment of subscription charges as acceptance of the terms, has been removed. This statement is found on the face page of the employer contract.

FOR MORE INFORMATION

Premera Blue Cross is required to provide the following information to prospective and renewing purchasers for review by interested employees. Please share the information included with this proposal with any interested employees:

Covered Benefits

The proposal shows which benefits are included on the quoted plan(s), including prescription drug benefits. If your employees request more detailed information, a summary of benefits is available from your sales representative. The summary of benefits shows applicable benefit limitations and includes information about additional benefits, including prescription drug benefits.

Member Costs

It is the responsibility of the employer to share with their employees any premium cost sharing requirements.

The proposal shows applicable deductible, coinsurance and copays for the quoted plan(s). A summary of benefits, available from your sales representative, provides more detail about deductibles, coinsurance and copays, for specific benefits, as applicable.

Additional information about our health plans and company procedures is available:

- Our product offerings,
- Benefit exclusions,
- Our prescription drug plans - the prescription drug list,
- Our provider directories,
- How we pay providers,
- Referral information,
- Prior authorization procedures,
- Documents referenced in the group contract,
- Annual accounting,
- Our confidentiality policies,
- Our grievance process,
- Our accreditation status and performance.

To receive this information on behalf of your employees, please contact your Premera Blue Cross sales representative. Many of these items, as well as summaries of benefits for many Premera Blue Cross plans, are also available at our website. Please visit www.premera.com.

Notification of Plan Changes

Please indicate below any other changes to the existing benefit plan at renewal, including a change in the Group's legal name or address, any affiliate or subsidiary additions or deletions, and revised eligibility requirements or IRS Section 125 Cafeteria Plan revisions. *Attach additional pages as necessary.*

Questions

If you have any questions about this renewal, please contact your Marketing Representative for assistance.

State-Mandated Benefit Offerings

GROUP NAME: Washington Biotechnology & Biomedical Association
GROUP NUMBER(S): 100000021
RENEWAL DATE: January 1, 2008

All health carriers must present the following state-mandated benefit offerings at renewal. **Please indicate and initial below which optional items you wish included in your contract.** If you would like additional information about these offerings, please contact your Premera Blue Cross representative.

If the state or federal government mandates any additional change in benefits after this renewal packet is issued, a supplemental notice will be provided.

| MANDATED OFFERING | CURRENTLY | IF TAKEN | YES | NO | INITIALS |
|---|---|---|-----|----|----------|
| Chiropractic Care – Plans D, E F, G, H | Combined with Osteopathic Spinal and Other Manipulations up to a calendar year maximum of 12 visits | On the same basis as any other care. | | | |
| TMJ Benefit – HSA Plan | Not covered. | Eligible medical and dental services paid as any other medical or dental condition up to a calendar year maximum of \$1,000 per member, and a lifetime benefit maximum of \$5,000 per member. | | | |

PLEASE NOTE: Rates will be provided upon request.

Mental Health Benefits Disclosure Statement

The following disclosure is provided as required by Chapter 284-43-810 of the Washington Administrative Code. It details benefit information relating to this plan's coverage for treatment of mental health conditions.

Copies of this disclosure are available for distribution to individual plan members or prospective members. Please contact your Account Executive to request additional copies.

Mental Health Benefit Questions and Answers

- a. What are the steps that must be taken to have outpatient mental health services paid for by my plan?**

| YES | NO | |
|-------------------------------------|-------------------------------------|--|
| <input checked="" type="checkbox"/> | | Direct self-referral to a participating provider, with no prior authorization or approval. |
| | <input checked="" type="checkbox"/> | Primary care provider referral required; Primary care provider may determine the number of visits. |
| | <input checked="" type="checkbox"/> | Preauthorization, predetermination of medical necessity, preverification of benefits and eligibility or referral required. |

- b. What information about my mental condition will anyone other than my mental health provider see?**

| | |
|-------------------------------------|--|
| <input checked="" type="checkbox"/> | No information, other than your diagnostic category and number of treatments you received. |
| | Diagnostic details. |
| | Treatment codes. |
| | Treatment plans, including expected outcomes. |
| | Progress notes. |
| | Other. |

- c. Do I have to pay a higher copay, deductible or other charges than I pay for my other covered medical services to get mental health services under this plan?**

| | SAME | LESS | MORE |
|---------------------------|-------------------------------------|------|------|
| Deductibles | <input checked="" type="checkbox"/> | | |
| Copays | <input checked="" type="checkbox"/> | | |
| Coinsurance | <input checked="" type="checkbox"/> | | |
| Other cost-sharing | | | |

d. What is the maximum number of medically necessary inpatient days and outpatient visits I can get each year under this plan?

| INPATIENT DAYS | OUTPATIENT VISITS | |
|----------------|-------------------|----------------------|
| | | Less than Ten |
| x | x | Eleven to Twenty |
| | | Twenty-one to Thirty |
| | | More than Thirty |
| | | Other |

e. What is the average number of outpatient visits this plan pays for people who have been provided mental health services?

| | |
|----------|----------------------|
| x | Less than Ten |
| | Eleven to Twenty |
| | Twenty-one to Thirty |
| | More than Thirty |
| | Other |

f. In which of the following circumstances where I might need mental health services would I find them excluded or subject to restrictions or limitations other than medical necessity?

| | |
|---|----------|
| Diagnostic testing to determine if a mental disorder exists. | x |
| A mental disorder has a congenital or physical basis, such as Tourette's Syndrome, or may be partially covered under the medical services portion of the health plan. | x |
| A court orders treatment. | x |
| Treatment surrounding self inflicted harm, such as a suicide attempt. | |
| There are diagnosed learning disabilities. | x |
| There is a diagnosed eating disorder. | |
| There is a diagnosed mental disorder related to sexual functioning, or a sex change. | x |
| Couples or marriage therapy. | x |
| Custodial care. | x |

g. What is this plan's most common goal in financing treatment in adults? In children?

| | |
|----------|---|
| x | Stabilization and symptom management |
| | Return to previous functioning |
| | Ongoing maintenance for long-term illness |