



B.I.G. Enterprises, Inc.

Business Success earned with Integrity administered with Generosity

Memorandum

To: B.I.G. Employees
From: John Palmer
Date: 9/11/2009
Re: Health Insurance Plan Modification

B.I.G. has decided to modify our existing health insurance coverage, due to rising costs. We will continue to pay 100% of the employee's portion of the premium, but we had to make some minor changes to our plan to reduce costs. I have included a summary of benefits, but two notable changes are:

- In-Network Copay increases \$10
- \$500 deductible for Out-of-Network

You will be receiving new ID cards and kits in the mail. These changes are effective June 1, 2009. If you have any questions, please feel free to contact me.

Thank you,
John Palmer

BlueChoice Opt-Out *Plus Open Access*

Summary of Benefits

SERVICES	In-Network You Pay	Out-Of-Network You Pay
ANNUAL DEDUCTIBLE³		
Individual	None	\$500
Individual & Child(ren)	None	\$1,000
Individual & Adult	None	\$1,000
Family	None	\$1,000
ANNUAL OUT-OF-POCKET LIMIT³		
Individual	\$3,300	\$2,500
Individual & Child(ren)	\$10,100	\$5,000
Individual & Adult	\$6,400	\$5,000
Family	\$10,100	\$5,000
LIFETIME MAXIMUM	Unlimited	\$2,000,000
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	\$10 per visit	Deductible, then 20% of Allowed Benefit*
24 months-13 years (immunization visit)	\$10 per visit	Deductible, then 20% of Allowed Benefit*
24 months-13 years (non-immunization visit)	\$20 per visit	Deductible, then 20% of Allowed Benefit*
14-17 years	\$20 per visit	Deductible, then 20% of Allowed Benefit*
Adult Physical Examination	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Routine GYN Visits	\$20 per visit	Deductible, then 20% of Allowed Benefit*
Mammograms	No charge ²	Deductible, then 20% of Allowed Benefit*
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge ²	Deductible, then 20% of Allowed Benefit*
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Diagnostic Services	No charge ²	Deductible, then 20% of Allowed Benefit*
X-ray and Lab Tests	No charge ²	Deductible, then 20% of Allowed Benefit*
Allergy Testing ⁸	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Allergy Shots ⁸	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Outpatient Physical, Speech and Occupational Therapy ⁹ (limited to 30 visits/condition/benefit period)	\$30 per visit	Deductible, then 30% of Allowed Benefit*
Outpatient Chiropractic ^{6,10} (limited to 20 visits/condition/benefit period)	\$30 per visit	Deductible, then 30% of Allowed Benefit*
EMERGENCY CARE AND URGENT CARE		
Physician's Office	\$20 PCP/\$30 Specialist per visit	Paid as in-network
Urgent Care Center	\$30 per visit	Paid as in-network
Hospital Emergency Room ⁵	\$35 per visit (waived if admitted)	Paid as in-network
Ambulance (if medically necessary)	No charge ²	Deductible, then 20% of Allowed Benefit*
HOSPITALIZATION⁹		
Inpatient Facility Services	No charge ²	Deductible, then 20% of Allowed Benefit*
Outpatient Facility Services	\$30 per visit	Deductible, then 20% of Allowed Benefit*
Inpatient Physician Services	No charge ²	Deductible, then 20% of Allowed Benefit*
Outpatient Physician Services	\$30 per visit	Deductible, then 20% of Allowed Benefit*
HOSPITAL ALTERNATIVES⁹		
Home Health Care	No charge ²	Deductible, then 20% of Allowed Benefit*
Hospice	No charge ²	Deductible, then 20% of Allowed Benefit*
Skilled Nursing Facility ⁶ (limited to 100 days/benefit period)	No charge ²	Deductible, then 20% of Allowed Benefit*

AB = Allowed Benefit

MSGR

SERVICES	In-Network You Pay	Out-Of-Network You Pay
MATERNITY		
Prenatal and Postnatal Office Visits	\$20 per visit	Deductible, then 20% of Allowed Benefit*
Delivery and Facility Services ⁹	No charge ²	Deductible, then 20% of Allowed Benefit*
Nursery Care of Newborn ⁴	No charge ²	Deductible, then 20% of Allowed Benefit*
Initial Office Consultation(s) for Infertility Services/Procedures	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
Artificial Insemination ¹	50% of Allowed Benefit (after diagnosis is confirmed)	Deductible, then 50% of Allowed Benefit*
In Vitro Fertilization Procedures ¹	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)⁹		
Inpatient Facility Services (limited to 60 days/benefit period)	No charge ²	Deductible, then 20% of Allowed Benefit*
Inpatient Physician Services	No charge ²	Deductible, then 20% of Allowed Benefit*
Outpatient Services (MH & SA)	30% of Allowed Benefit	Deductible, then 50% of Allowed Benefit*
Partial Hospitalization ⁶ (each day counts as 1/2 day toward inpatient limit)	No charge ²	Deductible, then 20% of Allowed Benefit*
Medication Management Visit	\$20 PCP/\$30 Specialist per visit	Deductible, then 20% of Allowed Benefit*
MISCELLANEOUS		
Durable Medical Equipment ⁹	No charge ²	Deductible, then 20% of Allowed Benefit*
Acupuncture	Not covered, unless medically necessary and Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Not covered, unless Plan approved for and Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy
Transplants ⁷	Covered as stated in Evidence of Coverage	Covered as stated in Evidence of Coverage
Hearing Aids for ages 0-18 (limited to \$1,400 max per hearing aid every 3 years) ⁶	No charge ²	Deductible, then 20% of Allowed Benefit*
VISION		
Routine Exam (Optometrist or Ophthalmologist) (limited to 1 visit/benefit period)	\$10 per visit at participating vision provider	Plan pays \$33 Member pays balance
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Plan pays allowance based on purchase, Member pays balance

¹ Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment option for infertility. However, assisted reproduction (AI) services performed as treatment option for infertility are only available under the terms of the members contract. Preauthorization required.

² No copayments or coinsurance.

³ The deductible can be met entirely by one Member or by combining eligible expenses of two or more members. The Out-of-Pocket can be met in the same way.

⁴ Newborns must be enrolled within 31 days of birth.

⁵ Emergency room copay applies to the deductible.

⁶ CareFirst BlueChoice may be providing your BlueChoice benefits on either a contract or calendar year basis. Please refer to your benefits contract to determine which method applies to your group benefit plan.

⁷ Please refer to your Evidence of Coverage to determine your coverage level.

⁸ If office copayment has been paid, additional office copayment not required for this service.

⁹ Preauthorization required.

¹⁰ Consultation for chiropractic services is charged the same as office visit for illness.

* Out-of-network coinsurances are based on a percentage of the out-of-network Allowed Benefit. If services are rendered from a nonparticipating provider, member is responsible for 100% of charges above the Allowed Benefit. However, if services are rendered by a participating provider, member is only responsible for amount up to the Allowed Benefit.

Copayments or portion of deductible may be required at point of sale while in deductible period. Members will never be required to pay more than CareFirst's Allowed Benefit for services rendered.

Note: Upon enrollment in CareFirst BlueChoice Opt-Out *Plus* Open Access, you will need to select a Primary Care Physician (PCP). To select a PCP, go to www.carefirst.com for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy form numbers: MD/CFBC/MSGR/GC (2/07) • MD/CFBC/MSGR/EOC (7/07) • GS-CC (MSGR) REV (9/05) • MD/CFBC/MSGR/SOB/ENHANCE (7/06) • MD/CFBC/DOC APPEAL (R. 6/06) • MD/CFBC/MSGR/BLUECARD (7/07) • MD/BC/VISION (MSGR) 12/01 • MD/CFBC/MSGR/DOCS (7/07) • MD/BC OOP/OA MSGR (R. 7/07) • MD/CFBC/MSGR/SOB/CORE (7/06)



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