BERNARD JOHNSON CORPORATION

INSURANCE BENEFITS SUMMARY

May, 2006

CARE FIRST BLUE CROSS BLUE SHIELD

Blue Preferred Plan

Monthly Payroll Deductions:	Employee:	$160.00
	E & Child	$363.00
	E & Spouse	$624.00
	Family	$862.00

SERVICES	In-Network You Pay[2]	Out-Of-Network You Pay[3]
ANNUAL DEDUCTIBLE[8]		
Individual	$1,000	
Individual & Child(ren)[7]	$2,000	(combined in- and out-of-network)
Individual & Adult	$2,000	
Family	$2,000	
ANNUAL OUT-OF-POCKET LIMIT[8]		
Individual	$3,400	
Individual & Child(ren)[7]	$6,800	(combined in- and out-of-network)
Individual & Adult	$6,800	
Family	$6,800	
LIFETIME MAXIMUM	$2,000,000 (combined in- and out-of-network)	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	$10 per visit	$10 per visit
24 months-13 years (immunization visit)	$10 per visit	$10 per visit
24 months-13 years (non-immunization visit)	$10 per visit	$10 per visit
14-17 years	$10 per visit	20% of Plan Allowance
Adult Physical Examination	$10 per visit	Deductible, then 20% of Plan Allowance
Routine GYN Visits	$10 per visit	Deductible, then 20% of Plan Allowance
Mammograms	No charge[9]	CareFirst participating provider: $0[3] Non-participating provider: Balance above Plan Allowance[3]
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge[9]	CareFirst participating provider: $0[3] Non-participating provider: Balance above Plan Allowance[3]
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	$10 per visit	Deductible, then 20% of Plan Allowance
Diagnostic Services	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
X-ray and Lab Tests	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Allergy Testing	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Allergy Shots	$5 per visit	Deductible, then 20% of Plan Allowance
Outpatient Physical, Speech and Occupational Therapy[4,6] (limited to 30 visits/condition/benefit period)	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Outpatient Chiropractic[4,6] (limited to 20 visits/benefit period)	No charge[9] after deductible	Deductible, then 20% of Plan Allowance

SERVICES	In-Network You Pay[2]	Out-Of-Network You Pay[3]
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$10 per visit	Deductible, then 20% of Plan Allowance
Urgent Care Center	$10 per visit	Deductible, then 20% of Plan Allowance
Hospital Emergency Room[5]	Deductible, then $35 per visit (waived if admitted)	Deductible, then $35 per visit (waived if admitted
Ambulance (if medically necessary)	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
HOSPITALIZATION[6]		
Inpatient Facility Services	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Outpatient Facility Services	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Inpatient Physician Services	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Outpatient Physician Services	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
HOSPITAL ALTERNATIVES		
Home Health Care	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Hospice	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Skilled Nursing Facility (limited to 100 days/benefit period)[6]	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
MATERNITY		
Prenatal and Postnatal Office Visits	$10 per visit	Deductible, then 20% of Plan Allowance
Delivery and Facility Services	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Nursery Care of Newborn	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Artificial Insemination[1]	Deductible, then 50% of Plan Allowance	Deductible, then 50% of Plan Allowance
In Vitro Fertilization Procedures[1]	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)		
Inpatient Facility Services (limited to 60 days/benefit period)	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Inpatient Physician Services	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Outpatient Services (MH & SA)	Deductible, then 20% of Plan Allowance	Deductible, then 35% of Plan Allowance
Partial Hospitalization[6] (each day counts as 1/2 day toward inpatient limit)	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Medication Management Visit	$10 per visit	Deductible, then 20% of Plan Allowance
MISCELLANEOUS		
Durable Medical Equipment	No charge[9] after deductible	Deductible, then 20% of Plan Allowance
Acupuncture	Not covered, unless Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Not covered, unless Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy
Transplants	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[9] after deductible	Deductible, then 20% of Plan Allowance
VISION		
Routine Exam (optometrist or ophthalmologist) (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $20 for optometrist, $30 for ophthalmologist
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

CARE FIRST BLUE CROSS BLUE SHIELD

Select Preferred Plan

Monthly Payroll Deductions:	Employee:	$182.00
	E & Child	$401.00
	E & Spouse	$720.00
	Family	$954.53

SERVICES	In-Network You Pay[2]	Out-Of-Network You Pay[3]
ANNUAL DEDUCTIBLE[8]		
Individual	$400	
Individual & Child(ren)[7]	$800	(combined in- and out-of-network)
Individual & Adult	$800	
Family	$800	
ANNUAL OUT-OF-POCKET LIMIT[8]		
Individual	$2,750	
Individual & Child(ren)[7]	$5,500	(combined in- and out-of-network)
Individual & Adult	$5,500	
Family	$5,500	
LIFETIME MAXIMUM	$2,000,000	
PREVENTIVE SERVICES		
Well-Child Care		
0-24 months	$10 per visit	40% of PA
24 months-13 years (immunization visit)	$10 per visit	40% of PA
24 months-13 years (non-immunization visit)	$10 per visit	40% of PA
14-17 years	Deductible, then 20% of PA	Deductible, then 40% of PA
Adult Physical Examination	Deductible, then 20% of PA	Deductible, then 40% of PA
Routine GYN Visits	Deductible, then 20% of PA	Deductible, then 40% of PA
Mammograms	Deductible, then 20% of PA	Deductible, then 40% of PA
Cancer Screening (Pap Test, Prostate and Colorectal)	Deductible, then 20% of PA	Deductible, then 40% of PA
OFFICE VISITS, LABS & TESTING		
Office Visits for Illness	Deductible, then 20% of PA	Deductible, then 40% of PA
Diagnostic Services	Deductible, then 20% of PA	Deductible, then 40% of PA
X-ray and Lab Tests	Deductible, then 20% of PA	Deductible, then 40% of PA
Allergy Testing	Deductible, then 20% of PA	Deductible, then 40% of PA
Allergy Shots	Deductible, then 20% of PA	Deductible, then 40% of PA
Outpatient Physical, Speech and Occupational Therapy[4,6] (limited to 30 visits/condition/benefit period)	Deductible, then 30% of PA	Deductible, then 50% of PA
Outpatient Chiropractic[4,6] (limited to 20 visits/benefit period)	Deductible, then 30% of PA	Deductible, then 50% of PA

SERVICES	In-Network You Pay[2]	Out-Of-Network You Pay[3]
EMERGENCY CARE AND URGENT CARE		
Physician's Office	Deductible, then 20% of PA	Deductible, then 40% of PA
Urgent Care Center	Deductible, then 20% of PA	Deductible, then 40% of PA
Hospital Emergency Room[5]	Deductible, then $35 per visit and 20% of PA (waived if admitted)	Deductible, then $35 per visit and 20% of PA (waived if admitted)
Ambulance (if medically necessary)	Deductible, then 20% of PA	Deductible, then 40% of PA
HOSPITALIZATION[4]		
Inpatient Facility Services	Deductible, then 20% of PA	Deductible, then 40% of PA
Outpatient Facility Services	Deductible, then 20% of PA	Deductible, then 40% of PA
Inpatient Physician Services	Deductible, then 20% of PA	Deductible, then 40% of PA
Outpatient Physician Services	Deductible, then 20% of PA	Deductible, then 40% of PA
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 20% of PA	Deductible, then 40% of PA
Hospice	Deductible, then 20% of PA	Deductible, then 40% of PA
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then 20% of PA	Deductible, then 40% of PA
MATERNITY		
Prenatal and Postnatal Office Visits	Deductible, then 20% of PA	Deductible, then 40% of PA
Delivery and Facility Services	Deductible, then 20% of PA	Deductible, then 40% of PA
Nursery Care of Newborn	Deductible, then 20% of PA	Deductible, then 40% of PA
Artificial Insemination[1]	Deductible, then 50% of PA	Deductible, then 50% of PA
In Vitro Fertilization Procedures[1]	Not covered	Not covered
MENTAL HEALTH (MH) AND SUBSTANCE ABUSE (SA)		
Inpatient Facility Services (limited to 60 days/benefit period)	Deductible, then 20% of PA	Deductible, then 40% of PA
Inpatient Physician Services	Deductible, then 20% of PA	Deductible, then 40% of PA
Outpatient Services (MH & SA)	Deductible, then 30% of PA	Deductible, then 50% of PA
Partial Hospitalization[6] (each day counts as 1/2 day toward inpatient limit)	Deductible, then 20% of PA	Deductible, then 40% of PA
Medication Management Visit	Deductible, then 20% of PA	Deductible, then 40% of PA
MISCELLANEOUS		
Durable Medical Equipment	Deductible, then 20% of PA	Deductible, then 40% of PA
Acupuncture	Not covered, unless Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy	Not covered, unless Plan approved for anesthesia and when services are rendered in conjunction with Physical Therapy
Transplants	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)	Deductible, then 20% of PA	Deductible, then 40% of PA
VISION		
Routine Exam (optometrist or ophthalmologist) (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $20 for optometrist, $30 for ophthalmologist
Eyeglasses and Contact Lenses	Discounts from participating Vision Centers	Not covered

ASSURANT EMPLOYEE BENEFITS

Monthly Deductions:		Employee:	$0
Included With		E & Child	$0
Medical Enrollment		E & Spouse	$0
Family	$0		

Services Provided:

Calendar Year Deductible	$50
Maximum Family Deductible	3 x
Benefit Year Maximum	$1,000
Class I Preventative Services	100%
Class II Basic Services	80%
Class III Major Services	50%
Class IV Orthodontic Services	50%

VISION SERVICE PLAN

Monthly Deductions:		Employee:	$0
Included With		E & Child	$0
Medical Enrollment		E & Spouse	$0
Family	$0		

Services Provided by Member Doctor:

Vision Exam	100% after $20 copay
Lenses	
Single Vision	$20/copay
Bifocal	$20/copay
Trifocal	$20/copay
Lenticular	$20/copay
Frames	Up to $120
Contact Lenses (Visually Necessary)	$20/copay
Contact Lenses (Elective)+contact lens exam(fitting&evaluation)	Up to $120