HARFORD COUNTY EDUCATION ASSOCIATION

NEGOTIATIONS PROPOSAL

MAY 27, 2010

All other proposals remain the same as previously proposed by HCEA.

ARTICLE XIV
Insurance

14.2 ~~Effective July 1 through June 30~~, The Board ~~will~~ **shall** make available ~~for the duration of the Agreement~~ the following health insurance programs to eligible employees who enroll in the programs: The Traditional health Insurance and Preferred Provider Program (PPN/PPO) plans and an HMO plan in effect as of November 2000.~~, or comparable plans providing comparable benefits and network.~~ **These programs shall contain the same specific plan benefits as described in the medical comparison charts found between pages 27 and 28 of the2009-2010 negotiated agreement.** ~~for summary of benefits~~. Participation in the Traditional health Insurance Plan will be limited to those employees enrolled in the Plan on July 1, 2001. Employees who elect to terminate their participation in the Traditional Insurance Plan after that date shall not be eligible to re-enroll.

For the PPN the in-network lifetime maximum will be unlimited, the in-network office visit co-pay is $15, or $20 for a specialist, and the out-of-network office visit costs are covered at 80% of the allowed benefit.

The co-pay schedule for prescription drugs and oral contraceptives is $10/$25/$40, and the co-pay for mail order drugs for maintenance medication is $20 for up to 100 day supply.

~~Effective July 1 through June 30,~~ the Board ~~will~~ **shall** similarly make available ~~for the duration of the Agreement~~ to eligible employees who elect to enroll therein the choice of either the standard dental insurance plan or the Preferred Provider Dental Insurance Plan in effect as of November 2000~~, or comparable plans providing comparable benefits~~. **These plans shall contain the same specific benefits as described in the dental charts** ~~See~~ **found between pages 27 and 28.** The benefit period maximum for dental services shall be $1500.

The Board will not provide two insurance programs, e.g. Blue Cross/Blue Shield and an HMO program; or two different HMO programs for any eligible employees or eligible members of their families. This applies to all employees and eligible members of their families whose spouses are also employees of the school system. However, if one employee's eligibility for participation is terminated for any reason, the other employee family member shall continue to be eligible for the existing coverage.

Effective July 1, 2001, employees enrolled in the Traditional Insurance Plan will be able to use their membership card at participating pharmacies to obtain a discount on prescriptions.

The Board ~~will~~ **shall** make available ~~for the duration of the Agreement~~ the opportunity for employees, who are eligible for health insurance, to participate in a Flexible Spending Account Plan. Employees enrolled in this Plan will be allowed to contribute up to

$2,500.00 for the payment of non-covered medical expenses and $5,000.00 for dependent care costs on a pre-tax basis. **Effective July 1, 2009 employees enrolled in the Flexible Spending Account Plan will be allowed to contribute up to $5,000.00 for the payment of non-covered medical expenses.**

The Board shall make available to eligible employees and their eligible family members, at no cost, an Employee Assistance Plan (EAP). The EAP made available to employees shall include the following components:

General Counseling	Stress
Relationship Issues	Anxiety
Parenting Issues	Financial Issues
Grief and Loss	Childcare Issues
Addiction	Caring for an Elderly Parent

In the event that an eligible employee seeks assistance from the EAP for a work-related stress issue, the contact person for the EAP shall be instructed to direct such inquiries to the Association in the first instance. In the event the Board wishes to add or delete services or to reduce the level of services provided to employees during the term of this Agreement, the Board shall notify the Association of its desire to negotiate such changes. Employee participation in and/or referral to the EAP shall be voluntary and confidential, except as to any disclosures required by applicable law. All personal treatment records generated as a result of an eligible individual's utilization of the EAP shall be maintained by the service provider and shall not be shared with the Board unless otherwise authorized by the eligible employee or the covered dependent, or by operation of applicable law. The contact person for the EAP services to be made available under this Agreement shall not be employed by the Board of Education.

14.3 The Board's rate of contribution to the coverage made available under 14.1 is 90% of the total premium. The Board's rate of contribution applicable to the coverage made available under 14.2 shall be 80% of the total premium for the Traditional Health Insurance Plan and 90% of the total premium for all other provided health and dental insurance plans.

Harford County Board of Education Medical Benefits Options
Effective For Plan Year July 1, 2009 - June 30, 2010

The Benefits	CareFirst BlueCross BlueShield Preferred Provider Organization	
	In-Network	Out-of-Network
DEDUCTIBLE	None	$200 Individual $400 Family aggregate (Deductible applies to all services unless otherwise nc
ANNUAL MAXIMUM	Combined in and out-of-network out-of-pocket maximum: $1,200 Individual/$2,400 Family	
LIFETIME MAXIMUM	Unlimited	
HOSPITAL		
Hospital Room/Semi-Private	365 days at 100% AB*	365 days at 80% AB*
Skilled Nursing Facility	100% AB* (must occur within 15 days of a prior hospital admission)	80% AB* (must occur within 15 days of a prior hospital admissi
Inpatient Rehabilitation	100% AB up to 70 days per calendar year (combined with out-of-network)*	80% AB* up to 70 days per calendar year (combined with in-network)
Outpatient Rehabilitation	100% AB	80% AB
Outpatient Surgery	100% AB	80% AB
Emergency Care	Accidental: 100% Within 72 hours Medical Emergency: $25 copay physician at emergency room plus $25 copay for emergency room. If admitted: 100% AB	Accidental: 100% AB Within 72 hours. Medical Emergency 80% AB if not admitted; 100% AB if admitted Deductible waived
PHYSICIAN SERVICES		
Surgeon	100% AB	80% AB
Assistant Surgeon	100% AB	100% AB, waive deductible
Anesthesiologist	100% AB	100% AB, waive deductible
In-Hospital Medical	100% AB	80% AB
MEDICAL SERVICES		
Office visits	$15 PCP/$20 Specialist office copay	80% AB
Diagnostic X-rays	100% AB	100% AB inpatient, waive deductible 80% AB outpati
Radiation Therapy	100% AB	80% AB
Chemotherapy	100% AB	80% AB
Laboratory tests	100% AB	100% AB inpatient, waive deductible 80% AB outpati
Allergy testing	100% AB	80% AB
Allergy Treatment/Injections	100% AB	80% AB
Physical, Speech and Occupational Therapy (combined visits)	$20 Specialist office; $25 OP Facility. 100 visit maximum per calendar year (occupational/speech combined in- and out-of-network)	80% AB. 100 visit maximum per calendar year (occupational/speech combined in- and out-of-networ
Chiropractic Care	Medical care, $20 Specialist office Therapy services, $20 office 100 visit maximum per calendar year combined with physical therapy.	Medical care 80% AB Therapy services, 80% of AB; 100 visit maximum per calendar year combined with physical therapy.
PREVENTIVE CARE		
Well Child Care/Immunization	$15 PCP/$20 Specialist office copay	80% AB deductible waived
Routine Physical Exam	Age 18+ one per calendar year; $15 PCP/$20 Specialist copay; $300 maximum including immunization and diagnostic tests	Age 18+ one per calendar year; 80% AB $300 maximum including immunization and diagnostic tests
Routine Mammography	100% AB (limited to 1 per 5yrs age 35-39; 1 per 24 Months age 40-49 and 1 per 12 months 50+)	80% AB waive deductible (Limited to 1 per 5yrs age 35-39; 1 per 24 months age 40-49 and 1 per 12 months 50+)

AB = Allowed Benefit
This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Group Benefit Guide or the Group Service Agreement. AB—Allowed Benefit. AWP—Average Wholesale Price.
** Precertification required or penalties may apply.*

CareFirst BlueCross BlueShield Traditional (closed plan; not accepting new enrollees)	BlueChoice HMO
$100	None
Stop Loss: $25,000	None
$250,000 of major medical benefit	None
Covered at 100% AB 365 days*	Covered in full
100% AB* (must occur within 15 days of a prior hospital admission)	Covered in full when authorized for up to 60 days per contract year (excludes custodial services)
100% AB up to 70 days per calendar year*	Combined with speech, physical, occupational and cognitive therapy and chiropractic services (maximum of 60 visits per condition per contract year)
80% AB after deductible	$15 Specialist Copay; combined with speech, physical, occupational and cognitive therapy and chiropractic services (maximum of 60 visits per condition per contract year)
100% AB	Covered in full
100% of AB for sudden & serious care within 72 hours of accident or trauma; thereafter 80% of AB after deductible	$25 copay, (waived if admitted) Urgent Care Center $15 copay
100% AB	Covered in full
100% AB	Covered in full
100% AB	Covered in full
100% AB	Covered in full
80% of AB after deductible	$10 PCP/$15 Specialist copay
100% of AB when medically necessary	100% after applicable copay
100% AB	$15 Specialist copay
100% AB	$15 Specialist copay
Covered at 100% AB	100% after applicable copay
80% AB after deductible	$10 PCP/$15 Specialist copay
80% AB after deductible	$10 PCP/$15 Specialist copay
Benefits available at 80% of AB after deductible is met: unlimited days/visits	Maximum of 60 visits per condition per contract year. $15 Specialist copay Combined with speech and occupational therapy.
80% AB after deductible	$15 Specialist copay; combined with physical, speech and occupational therapy.
80% AB. No deductible.	$10 PCP/$15 Specialist copay
No benefit	$10 PCP/$15 Specialist copay per visit One per calendar year with PCP recommendation
100% AB (limited to 1 per 5yrs age 35-39; 1 per 24 months age 40-49; and 1 per 12 months 50+)	Applicable copay; annually age 40+

Harford County Board of Education Medical Benefits Options *(continued)*
Effective For Plan Year July 1, 2009 - June 30, 2010

The Benefits	CareFirst BlueCross BlueShield Preferred Provider Organization	
	In-Network	Out-of-Network
Routine Gynecological Exam	One per calendar year. $15 copay	One per calendar year. 80% AB
Eye Exams	No Benefit	No Benefit
Eye Glasses	No benefit	No Benefit
SPECIAL SERVICES		
Durable Medical Equipment	100% AB	80% AB
Home Health Care Visits*	Facility: 100% AB* Physician: $20 Specialist copay	Facility: 100% AB* Deductible waived Physician: 80% AB
Hospice	100% AB*	100% AB* Deductible waived
Maternity Care	100% AB	80% AB
Nursery Care (Must be enrolled within 30 days)	100% AB	80% AB
Family Planning	No benefit	No Benefit
Infertility Services	100% AB, pre-approval required. Artificial Insemination - 100% AB, pre-approval required; Invitro Fertilization - 100% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	80% AB, pre-approval required. Artificial Insemination - 80% AB, pre-approval required; Invitro Fertilization - 80% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)
Ambulance When Medically Necessary	100% AB private ground and air ambulance only	100% AB waive deductible private ground and air ambulance only
Adult Hearing Benefits (once every 36 months)	100% AB after $15 PCP/$20 Specialist copay	80% AB after deductible
Child Hearing Benefits (once every 36 months)	100% AB	80% AB after deductible
MENTAL HEALTH SERVICES		(administered by Magellan Behavioral Health)
Inpatient Care	100% AB up to 60 days combined with inpatient substance abuse*	80% AB up to 60 days combined with inpatient substance abuse*
Outpatient Care	Visits 1–5, 80% Visits 6–30, 65% Visits 31+, 50% Combined with Outpatient Substance Abuse*; Precertification required prior to the 9th visit or penalties may apply	Visits 1–5, 80% Visits 6–30, 65% Visits 31+, 50% after deductible Combined with Outpatient Substance Abuse*; Precertification required prior to the 9th visit or penalties may apply
SUBSTANCE ABUSE		
Inpatient Diagnosis & Medical Treatment	Combined with Inpatient Mental Health Services*	Combined with Inpatient Mental Health Services*
Outpatient Care	Combined with Outpatient Mental Health Services. Precertification required prior to the 9th visit or penalty may apply.	Combined with Outpatient Mental Health Services. Precertification required prior to the 9th visit or penalty may apply.
PRESCRIPTION DRUGS		
Prescription Drug	$10 copay generic drug (Tier 1) $25 copay preferred brand (Tier 2) $40 copay non-preferred brand (Tier 3) (Maintenance medication up to 100 day supply 1 X copay)	
Mail Order Drug	Walgreens Mail Service Prescription Program for maintenance medication.$20 copay - Up to 100 day supply	
Oral Contraceptives	$10 copay generic drug (Tier 1) $25 copay preferred brand (Tier 2) $40 copay non- preferred brand (Tier 3) (Up to 100 day supply 1 X copay)	

CareFirst BlueCross BlueShield Traditional (closed plan; not accepting new enrollees)	BlueChoice HMO
No benefit	$10 copay per visit self-referral
No benefit for routine exam	$25 copay per annual visit no-referral
No Benefit	Discounts available at participating optical centers.
80% AB after deductible	Covered in Full
100% of AB when medically necessary as an alternative to hospitalization; 90 days maximum per calendar year (Home Health Aide limited to 40 visits) then 80% after deductible for additional 90 days	Covered in Full
100% of AB* Respite care - 14 days per year	Covered in full
Inpatient hospital care covered at 100% of AB for Participating Providers Pre & Post Natal covered 80% after deductible	$10 copay to confirm pregnancy: covered in full thereafter Birthing Center - covered in full
100% of AB for first pediatric visit in hospital or home, if home delivery	Covered in full
No Benefit	$10 copay
Covered at 100% AB, pre-approval required; Artificial Insemination - Covered at 100% AB, pre-approval required; Invitro Fertilization - Covered at 100% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Pre-approval required Artificial Insemination - 50% copayment of charges (limited to 6 cycles per lifetime) Invitro Fertilization - 50% copayment of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)
80% of AB after deductible private ground and air ambulance only	Covered in full
80% AB after deductible	$10 PCP/$15 Specialist copay
100% AB; no deductible	Limited to a maximum of $1,400 every 36 months for one hearing aid for each hearing impaired ear; under 18 only
Covered at 100% AB up to 60 days combined with Inpatient Substance Abuse*	Same as any other illness. Covered in full.
Visits 1–5, 80% Visits 6–30, 65% Visits 31+, 50% after deductible Combined with Outpatient Substance Abuse*; Precertification required prior to the 9th visit or penalties may apply	Visits 1-5, 80% Visits 6-30, 65% Visits 31+, 50% coinsurance Combined with Outpatient Substance Abuse
Combined with Inpatient Mental Health*	Covered in full
Outpatient Facility—100% of AB up to $3,000, then combined with Outpatient Mental Health	Visits 1-5, 80% Visits 6-30, 65% Visits 31+, 50% coinsurance paid by plan Combined with Outpatient Mental Health Services
Present Membership Card at participating pharmacy, Member pay 100% AWP and then submit to medical plan to cover 80% of AB after deductible for prescription drugs	$5 copay – generic drug (Tier 1) $15 copay – preferred brand (Tier 2) $35 copay – non-preferred brand (Tier 3) (Maintenance drugs: 90 day supply, 3 times retail copay)
Walgreens Mail Service Prescription Program for maintenance medication $20 copay - Up to 100 day supply	Walgreens Mail Service - 3X retail copay
Present Membership Card at participating pharmacy, Member pay 100% AWP and then submit to medical plan to cover 80% of AB after deductible for prescription drugs	$5 copay – generic drug (Tier 1) $15 copay – preferred brand (Tier 2) $35 copay – non-preferred brand (Tier 3) (90 day supply for 3 times copay)

Delta Dental Group Number 00528 - PPO

The following information is not intended or designed to replace or serve as an Evidence of Coverage or Summary Plan Description for the program. If you have specific questions regarding benefit structure, limitations or exclusions, consult your company's benefits representative for the provisions specified in your Group Dental Contract.

BENEFIT HIGHLIGHTS FOR DELTA DENTAL PPO

WHO'S ELIGIBLE	Primary enrollee, spouse and eligible dependent children to the end of the calendar year that dependent turns 19 or the end of the calendar year of 25th birthday if dependent is full-time student
DEDUCTIBLES	In-PPO Network: $25 per person, $50 per family, per plan year Out-Of-PPO Network: $50 per person, $150 per family, per plan year
DEDUCTIBLE WAIVED FOR DIAGNOSTIC & PREVENTIVE?	In-PPO Network: Yes ☒ No ☐ Out-Of-PPO Network: Yes ☒ No ☐
ANNUAL MAXIMUM	The maximum benefit paid per plan year is $1500 per person In-PPO Network The maximum benefit paid per plan year is $1500 per person Out-Of-PPO Network
ANNUAL MAXIMUM WAIVED FOR DIAGNOSTIC & PREVENTIVE?	In-PPO Network: Yes ☒ No ☐ Out-Of-PPO Network: Yes ☒ No ☐

BENEFITS AND COVERED SERVICES*	In-PPO Network**	Out-Of-PPO Network**
DIAGNOSTIC & PREVENTIVE BENEFITS – Oral examinations, routine cleanings, x-rays, fluoride treatment, space maintainers, sealants (covered on first and second unrestored permanent molars only)	100 %	65 %
BASIC BENEFITS – Fillings, denture repair and relining, stainless steel crowns, bridges, bridge repair and recementation, posterior composites	80 %	50 %
MAJOR BENEFITS – Crowns, inlays, onlays and cast restorations	50 %	30 %
ENDODONTICS – Root canals	80 %	50 %
PERIODONTICS – Gum treatment	80 %	50 %
ORAL SURGERY – Incisions, excisions, surgical removal of tooth including simple extractions	80 %	50 %
SURGICAL REMOVAL OF IMPACTED TEETH	100 %	65 %
PROSTHODONTICS – Dentures	50 %	30 %
ORTHODONTIC BENEFIT children only	50 %	50 %
ORTHODONTIC MAXIMUM	$ 800 Lifetime	$ 800 Lifetime

* *Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.*

** *Fees are based on PPO fees for in-network dentists and PPO fees for out-of-network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.*

DELTA DENTAL Delta Dental of Pennsylvania

Customer Service **www.deltadentalins.com**
800-932-0783 (Business Hours: 8 am to 8 pm ET)
Claims Address
One Delta Drive, Mechanicsburg, PA 17055

3/09

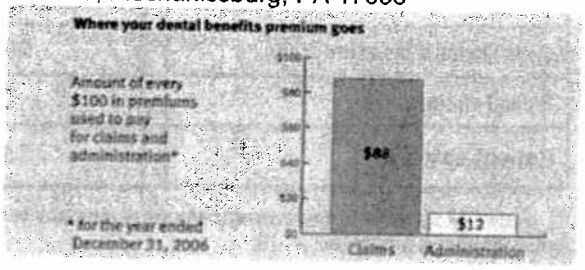
Maryland law requires we make the following statement:

Our compensation to physicians who offer health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary or capitation. Bonuses may be used with these various types of payment methods. If you desire additional information about our methods of paying physicians, or if you want to know which method(s) apply to your physician, please call Delta Dental at 800-932-0783 or write to: Delta Dental of Pennsylvania, One Delta Drive, Mechanicsburg, PA 17055.

Please note that the benefit payments made by Delta Dental to dentists, other dental care providers or enrollees are based on fee-for-service payment mechanisms and do not include salary, capitation or bonuses.

In Maryland, Delta Dental PPO and Delta Dental Premier are underwritten by Delta Dental of Pennsylvania, a not-for-profit dental service company.

FORM # HLT PPO2 DDP



Rev#2 6/07

Delta Dental Group Number 00528 - PPO Plus Premier

The following information is not intended or designed to replace or serve as an Evidence of Coverage or Summary Plan Description for the program. If you have specific questions regarding benefit structure, limitations or exclusions, consult your company's benefits representative for the provisions specified in your Group Dental Contract.

BENEFIT HIGHLIGHTS FOR DELTA DENTAL PPO

WHO'S ELIGIBLE	Primary enrollee, spouse and eligible dependent children to the end of the calendar year that dependent turns 19 or the end of the calendar year of 25th birthday if dependent is full-time student
DEDUCTIBLES	In-PPO Network: $25 per person, $50 per family, per plan year Out-Of-PPO Network: $25 per person, $50 per family, per plan year
DEDUCTIBLE WAIVED FOR DIAGNOSTIC & PREVENTIVE?	In-PPO Network: Yes ☒ No ☐ Out-Of-PPO Network: Yes ☒ No ☐
ANNUAL MAXIMUM	The maximum benefit paid per plan year is $1500 per person In-PPO Networ The maximum benefit paid per plan year is $1500 per person Out-Of-PPO Network
ANNUAL MAXIMUM WAIVED FOR DIAGNOSTIC & PREVENTIVE?	In-PPO Network: Yes ☒ No ☐ Out-Of-PPO Network: Yes ☒ No ☐

BENEFITS AND COVERED SERVICES*	In-PPO Network**	Out-Of-PPO Network**
DIAGNOSTIC & PREVENTIVE BENEFITS -- Oral examinations, routine cleanings, x-rays, fluoride treatment, space maintainers, sealants (covered on first and second unrestored permanent molars only)	100 %	100 %
BASIC BENEFITS -- Fillings, stainless steel crowns, posterior composites	100 %	100 %
MAJOR BENEFITS -- Crowns, inlays, onlays and cast restorations	0 %	0 %
ENDODONTICS -- Root canals	100 %	100 %
PERIODONTICS -- Gum treatment	0 %	0 %
ORAL SURGERY -- Incisions, excisions, surgical removal of tooth including simple extractions	100 %	100 %
PROSTHODONTICS -- Bridges, dentures	0 %	0 %

* *Limitations or waiting periods may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.*

** *Fees are based on PPO fees for in-network dentists and the MPA (maximum plan allowance) for out-of-network dentists. Reimbursement is paid on Delta Dental contract allowances and not necessarily each dentist's actual fees.*

SAMPLE CLAIM SAVINGS

	IN-PPO NETWORK	OUT-OF-PPO NETWORK	
	DELTA DENTAL PPO DENTISTS	DELTA DENTAL PREMIER DENTISTS	NON-DELTA DENTAL DENTISTS
Dentist bills	$180.00	$180.00	$180.00
Dentist accepts as payment in full	$90.00 (Delta Dental's agreed-upon fee)	$130.00 (Delta Dental's agreed-upon fee)	$180.00 (No fee agreement with Delta Dental)
Delta Dental's payment 100%	$90.00	$130.00	$130.00
Patient share*	$0.00	$0.00	$50.00
Patient savings	**$50.00**	**$50.00**	**$0.00**

* Patient's share is the coinsurance/copayment, any remaining deductible, any amount over the annual maximum and any servi your plan does not cover.

** If you visit a non-network dentist, Delta Dental will send the benefit payment directly to you. You are responsible for paying the non-network dentist's total fee, which may include amounts in excess of your share of your plan's contract allowance.