Harford County Public Schools True Hourly Rate and Annual Salary Schedule for Bus Drivers and Attendants Effective July 1, 2019										
Grade	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Drivers	$15.55	$16.02	$16.49	$16.98	$17.50	$18.02	$18.57	$19.13	$19.70	$20.29
5 Hours (.625)	$13,991	$14,414	$14,845	$15,286	$15,748	$16,220	$16,712	$17,214	$17,726	$18,257
6 Hours (.75)	$16,790	$17,297	$17,814	$18,344	$18,898	$19,464	$20,054	$20,657	$21,271	$21,908
7 Hours (.875)	$19,588	$20,179	$20,783	$21,401	$22,047	$22,708	$23,397	$24,099	$24,816	$25,560
8 Hours (1.0)	$22,386	$23,062	$23,752	$24,458	$25,197	$25,952	$26,739	$27,542	$28,361	$29,211
Grade	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Attendants	$11.56	$11.91	$12.27	$12.64	$13.01	$13.40	$13.81	$14.23	$14.65	$15.09
5 Hours (.625)	$10,408	$10,720	$11,041	$11,372	$11,713	$12,064	$12,426	$12,807	$13,189	$13,580
6 Hours (.75)	$12,490	$12,864	$13,249	$13,646	$14,056	$14,477	$14,912	$15,368	$15,827	$16,296
7 Hours (.875)	$14,571	$15,008	$15,457	$15,921	$16,398	$16,890	$17,397	$17,930	$18,465	$19,012
8 Hours (1.0)	$16,653	$17,152	$17,665	$18,195	$18,741	$19,303	$19,882	$20,491	$21,103	$21,728

Original

Employees on this salary schedule receive a $750 longevity increment after 14, 19, and 24 years of continuous service with the Harford County Public Schools.
Effective July 1, 2007, all Harford County Public Schools experience will count towards longevity increments

Harford County Public Schools
Salary Schedule for Food Service Employees
Effective July 1, 2019

	Step									
	1	2	3	4	5	6	7	8	9	10
General Worker										
3 Hours	$7,221	$7,438	$7,660	$7,890	$8,127	$8,371	$8,622	$8,881	$9,147	$9,422
3.5 Hours	$8,423	$8,677	$8,936	$9,204	$9,481	$9,766	$10,058	$10,361	$10,671	$10,991
6 Hours	$14,441	$14,875	$15,320	$15,780	$16,254	$16,742	$17,244	$17,762	$18,294	$18,843
Satellite Kitchen Asst.										
6 Hours	$17,793	$18,327	$18,877	$19,414	$19,996	$20,596	$21,213	$21,850	$22,505	$23,180
7 Hours	$20,757	$21,380	$22,022	$22,648	$23,327	$24,027	$24,747	$25,490	$26,254	$27,042
Production Center Asst.										
6 Hours	$18,100	$18,643	$19,202	$19,777	$20,400	$20,982	$21,612	$22,260	$22,928	$23,616

Original

NOTE: Salaries for personnel who work less than the listed number of hours are prorated accordingly.

Employees on this salary schedule receive a $750 longevity increment after 14, 19, and 24 years of continuous service with the Harford County Public Schools. Effective July 1, 2007, all Harford County Public Schools experience will count towards longevity increments.

Harford County Public Schools
Salary Schedule for Twelve Month AFSCME Employees
Effective July 1, 2019

Grade | Step	1	2	3	4	5	6	7	8	9	10
1	$26,797	$27,601	$28,430	$29,283	$30,162	$31,066	$31,998	$32,957	$33,946	$34,965
2	$28,696	$29,557	$30,445	$31,358	$32,298	$33,268	$34,266	$35,293	$36,352	$37,443
3	$30,592	$31,510	$32,454	$33,427	$34,431	$35,464	$36,528	$37,624	$38,752	$39,915
4	$32,489	$33,463	$34,467	$35,500	$36,565	$37,662	$38,793	$39,956	$41,155	$42,391
5	$34,762	$35,806	$36,880	$37,985	$39,126	$40,299	$41,507	$42,754	$44,036	$45,358
6	$37,045	$38,156	$39,301	$40,480	$41,694	$42,946	$44,233	$45,559	$46,928	$48,335
7	$39,306	$40,486	$41,700	$42,952	$44,241	$45,568	$46,935	$48,343	$49,792	$51,286
8	$41,586	$42,833	$44,117	$45,442	$46,805	$48,209	$49,655	$51,145	$52,679	$54,259
9	$44,237	$45,563	$46,931	$48,338	$49,789	$51,282	$52,821	$54,405	$56,037	$57,718
10	$46,894	$48,301	$49,751	$51,243	$52,780	$54,364	$55,994	$57,674	$59,404	$61,187
11	$49,546	$51,032	$52,562	$54,140	$55,765	$57,437	$59,161	$60,935	$62,763	$64,646
12	$52,202	$53,769	$55,381	$57,044	$58,754	$60,517	$62,332	$64,203	$66,129	$68,113

Original

Employees on this salary schedule receive a $750 longevity increment after 14, 19, and 24 years of continuous service with the Harford County Public Schools. Effective July 1, 2007, all Harford County Public Schools experience will count towards longevity increments.

Shift Differential: Employees who work second shift will receive a forty-cents per hour differential.

Harford County Public Schools

Salary Schedule for Twelve Month AFSCME Employees
(Second Shift)
Effective July 1, 2019

Grade | Step	1	2	3	4	5	6	7	8	9	10
1	$27,629	$28,433	$29,262	$30,115	$30,994	$31,898	$32,830	$33,789	$34,778	$35,797
2	$29,528	$30,389	$31,277	$32,190	$33,130	$34,100	$35,098	$36,125	$37,184	$38,275
3	$31,424	$32,342	$33,286	$34,259	$35,263	$36,296	$37,360	$38,456	$39,584	$40,747
4	$33,321	$34,295	$35,299	$36,332	$37,397	$38,494	$39,625	$40,788	$41,987	$43,223
5	$35,594	$36,638	$37,712	$38,817	$39,958	$41,131	$42,339	$43,586	$44,868	$46,190
6	$37,877	$38,988	$40,133	$41,312	$42,526	$43,778	$45,065	$46,391	$47,760	$49,167
7	$40,138	$41,318	$42,532	$43,784	$45,073	$46,400	$47,767	$49,175	$50,624	$52,118
8	$42,418	$43,665	$44,949	$46,274	$47,637	$49,041	$50,487	$51,977	$53,511	$55,091
9	$45,069	$46,395	$47,763	$49,170	$50,621	$52,114	$53,653	$55,237	$56,869	$58,550
10	$47,726	$49,133	$50,583	$52,075	$53,612	$55,196	$56,826	$58,506	$60,236	$62,019
11	$50,378	$51,864	$53,394	$54,972	$56,597	$58,269	$59,993	$61,767	$63,595	$65,478
12	$53,034	$54,601	$56,213	$57,876	$59,586	$61,349	$63,164	$65,035	$66,961	$68,945

Original

Employees on this salary schedule receive a $750 longevity increment after 14, 19, and 24 years of continuous service with the Harford County Public Schools. Effective July 1, 2007, all Harford County Public Schools experience will count towards longevity increments.

Shift Differential: Employees who work second shift will receive a forty-cents per hour differential.

Harford County Board of Education
Medical Benefits Options

Effective for Plan Year July 1, 2019 – June 30, 2020

Medical Benefits Options

Effective for plan year July 1, 2019–June 30, 2020

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
DEDUCTIBLE—CONTRACT YEAR JULY 1–JUNE 30	$150 Individual / $300 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$50 Individual / $100 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)
MEDICAL OUT-OF-POCKET MAXIMUM	$6,600 Individual/$13,200 Family (integrated with Rx out-of-pocket maximum)	$1,200 Individual /$2,400 Family (combined in- and out-of-network)
LIFETIME MAXIMUM	Unlimited	Unlimited
HOSPITAL		
Hospital Room/Semi-Private*	100% AB	100% AB
Skilled Nursing Facility*	100% AB (limited to 60 days/contract year)	100% AB
Inpatient Rehabilitation*	100% AB (limited to 90 days/contract year)	100% AB
Outpatient Surgery	100% AB	100% AB
Emergency Care**	Emergency Room—$75 copay (waived if admitted); Urgent Care Center—$35 copay	Emergency Room—$75 copay (waived if admitted); Urgent Care Center—$20 copay
PHYSICIAN SERVICES		
Surgeon	100% AB	100% AB
Assistant Surgeon	100% AB	100% AB
Anesthesiologist	100% AB	100% AB
In-Hospital Medical	100% AB	100% AB
MEDICAL SERVICES		
Office Visits	$15 PCP/$20 Specialist copay	$15 PCP/$20 Specialist copay
Outpatient Facility	100% AB	100% AB
Outpatient Physician	$15 PCP/$20 Specialist copay	$15 PCP/$20 Specialist copay
Diagnostic X-rays	100% AB	100% AB
Radiation Therapy	$20 Specialist copay	100% AB
Chemotherapy	$20 Specialist copay	100% AB
Laboratory Tests	100% AB (LabCorp only)	100% AB (LabCorp only)
Allergy Testing	$15 PCP/$20 Specialist copay	100% AB
Allergy Treatment/Injections	$15 PCP/$20 Specialist copay	100% AB

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.

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
$50 Individual / $100 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$250 Individual / $500 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$150 Individual / $300 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)	$350 Individual / $700 Family aggregate (Deductible applies to all services unless otherwise noted; does not apply to Rx benefits)
$1,200 Individual /$2,400 Family (combined in- and out-of-network)		$2,400 Individual / $4,800 Family (combined in- and out-of-network)	
		Unlimited	
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
Emergency Room—$75 copay (waived if admitted); Urgent Care Center—$25 copay	Emergency Room—$75 copay (waived if admitted); Urgent Care Center—80% AB	Emergency Room—$100 copay (no deductible—waived if admitted); Urgent Care Center—$25 copay (no deductible)	Emergency Room—$100 copay (no deductible—waived if admitted); Urgent Care Center—70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	Paid as Level 2	90% AB	Paid as in-network
100% AB	Paid as Level 2	90% AB	Paid as in-network
100% AB	80% AB	90% AB	70% AB
$20 PCP/$25 Specialist copay	80% AB	$20 PCP / $25 Specialist copay (no deductible)	70% AB
100% AB	80% AB	100% AB	70% AB
$30 copay	80% AB	$30 copay	70% AB
100% AB	Inpatient—Paid as Level 2 Office & Outpatient—80% AB	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	Inpatient—Paid as Level 2 Office & Outpatient—80% AB	90% AB	90% AB inpatient / 70% AB office
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB

* Precertification required or penalties may apply.
** Overnight stays for observation are not considered an inpatient admission.

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
MEDICAL SERVICES (CONTINUED)		
Physical, Speech and Occupational Therapy (combined visits)	$20 Specialist copay; 60 visit maximum per condition per contract year combined with speech and occupational therapy	$20 Specialist copay; 100 visit maximum per contract year combined with speech and occupational therapy
Chiropractic Care (Spinal Manipulation)	$20 Specialist copay; 60 visit maximum per condition per contract year	$20 Specialist copay
Acupuncture	Not covered	$20 Specialist copay
PREVENTIVE CARE		
Well Child Care/Immunization	100% AB (no deductible)	100% AB (no deductible)
Routine Physical Exam	100% AB (no deductible)	100% AB (no deductible)
Breast Cancer Screening/ Routine Mammography	100% AB (no deductible)	100% AB (no deductible)
Prostate Cancer Screening	100% AB (no deductible)	100% AB (no deductible)
Routine Gynecological Exam (one per contract year)	100% AB (no deductible)	100% AB (no deductible)
Eye Exams	$10 copay per annual visit no-referral (Davis Vision provider) (no deductible)	$10 copay per annual visit no-referral (Davis Vision provider) (no deductible)
Eye Glasses/Lenses/Contact Lenses	Discounts available; See pages 30–31	Discounts available; See pages 30–31
SPECIAL SERVICES		
Durable Medical Equipment	100% AB	100% AB
Home Health Care Visits*	100% AB	100% AB
Hospice*	100% AB	100% AB
Maternity Care (Pre/Post/ Delivery)	100% AB	100% AB
Nursery Care (Must be enrolled within 30 days)	100% AB	100% AB
Infertility Services	Pre-approval required Artificial Insemination—50% AB of charges (limited to 6 attempts per live birth); In Vitro Fertilization—50% AB of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Pre-approval required Artificial Insemination—100% AB of charges (limited to 6 attempts per live birth); In Vitro Fertilization—100% AB of charges (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)
Lapband Benefits	100% AB	100% AB
Surgical Treatment for Morbid Obesity (Gastric Bypass & Gastric Sleeve)	Not Covered	Not Covered

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.

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
$25 Specialist office; $30 OP Facility; $30 OP Professional; 100 visit maximum per contract year (occupational/ speech combined in- and out-of-network)	80% AB; 100 visit maximum per contract year (occupational/ speech combined in- and out-of-network)	$25 Specialist office copay; $30 OP Facility, $30 OP Professional (no deductible); 100 visit maximum per contract year (occupational/speech combined in- and out-of-network)	70% AB; 100 visit maximum per contract year (occupational/ speech combined in- and out-of-network)
$25 Specialist copay	80% AB	$25 Specialist copay	70% AB
$25 Specialist copay	80% AB	$25 Specialist copay	70% AB
100% AB (no deductible)	80% AB	100% AB (no deductible)	70% AB
100% AB (no deductible)	80% AB	100% AB (no deductible)	70% AB
100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)	100% AB (no deductible)
100% AB (no deductible)	80% AB	100% AB (no deductible)	70% AB
$10 copay per annual visit no-referral (Davis Vision provider) (no deductible)		No Benefit	No Benefit
Discounts available; See pages 30–31		No Benefit	No Benefit
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	100% AB	70% AB
100% AB	80% AB	90% AB	70% AB
Artificial Insemination—100% AB, pre-approval required (limited to 6 attempts per live birth); In Vitro Fertilization—100% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination—80% AB, pre-approval required (limited to 6 attempts per live birth); In Vitro Fertilization—80% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination—90% AB, pre-approval required (limited to 6 attempts per live birth); In Vitro Fertilization—90% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)	Artificial Insemination—70% AB, pre-approval required (limited to 6 attempts per live birth); In Vitro Fertilization—70% AB, pre-approval required; (limited to 3 attempts per live birth not to exceed a maximum lifetime limit of $100,000)
100% AB	80% AB	90% AB	70% AB
Not Covered	Not Covered	Not Covered	Not Covered

* Precertification required or penalties may apply.
** Mandatory generic substitution—see the CareFirst Drug Program section on page 21.

The Benefits	BlueChoice HMO OpenAccess BlueChoice Providers	Level 1 BlueChoice Providers
SPECIAL SERVICES (CONTINUED)		
Ambulance When Medically Necessary (surface, air, private, and public)	100% AB	100% AB
Hearing Exam	$20 copay	$20 copay
Hearing Aids (one per hearing impaired ear every 36 months)	100% AB	100% AB
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Inpatient Care*	100% AB	100% AB
Outpatient Facility	100% AB	100% AB
Office Visits	$15 copay	$15 copay
PRESCRIPTION DRUGS USING FORMULARY 2		
Prescription Drug Out-of-Pocket Max.	$6,600 Individual / $13,200 Family (integrated with medical out-of-pocket maximum)	$5,400 Individual / $10,800 Family
Retail Prescription Drug**	$10 copay – Generic drug (Tier 1) $20 copay – Preferred Brand (Tier 2) $40 copay – Non-preferred Brand (Tier 3) Maintenance drugs: 90 day supply, 2 times retail copay at CVS only: $20 copay – Generic drug (Tier 1) $40 copay – Preferred Brand (Tier 2) $80 copay – Non-preferred Brand (Tier 3)	$15 copay Generic drug (Tier 1) $30 copay Preferred Brand (Tier 2) $45 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 1 times retail at CVS only: $15 copay – Generic drug (Tier 1) $30 copay – Preferred Brand (Tier 2) $45 copay – Non-preferred Brand (Tier 3)
Mail Order Drug**	CVS Caremark Mail Order – 2 times retail copay – up to 90 day supply $20 copay – Generic drug (Tier 1) $40 copay – Preferred Brand (Tier 2) $80 copay – Non-preferred Brand (Tier 3)	CVS Caremark Mail Order Prescription Program for maintenance medication 1 times copay – Up to 90 day supply $15 copay – Generic drug (Tier 1) $30 copay – Preferred Brand (Tier 2) $45 copay – Non-preferred Brand (Tier 3)
Oral Contraceptives**	100% AB	100% AB
Diabetic supplies	100% AB	100% AB

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.

Triple Option		CareFirst BlueCross BlueShield Preferred Provider Organization CORE	
Level 2 BlueCross BlueShield PPO Providers	Level 3 Participating and Non-participating Providers	In-network BlueCross BlueShield PPO Providers	Out-of-network Participating and Non-participating Providers
100% AB	Paid as Level 2	90% AB	Paid as in-network
$25 copay	80% AB	$25 copay	70% AB
100% AB	80% AB	90% AB (no deductible)	70% AB
100% AB	80% AB	90% AB	70% AB
100% AB	80% AB	90% AB	70% AB
$20 copay	80% AB	$20 copay (no deductible)	70% AB
$5,400 Individual / $10,800 Family		$4,200 Individual / $8,400 Family	
$15 copay Generic drug (Tier 1) $30 copay Preferred Brand (Tier 2) $45 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 1 times retail at CVS only: $15 copay – Generic drug (Tier 1) $30 copay – Preferred Brand (Tier 2) $45 copay – Non-preferred Brand (Tier 3)		$15 copay Generic drug (Tier 1) $30 copay Preferred Brand (Tier 2) $45 copay Non-preferred Brand (Tier 3) Maintenance medication up to 90 day supply 1 times retail at CVS only: $15 copay – Generic drug (Tier 1) $30 copay – Preferred Brand (Tier 2) $45 copay – Non-preferred Brand (Tier 3)	
CVS Caremark Mail Order Prescription Program for maintenance medication 1 times copay – Up to 90 day supply $15 copay – Generic drug (Tier 1) $30 copay – Preferred Brand (Tier 2) $45 copay – Non-preferred Brand (Tier 3)		CVS Caremark Mail Order Prescription Program for maintenance medication 1 times copay – Up to 90 day supply $15 copay – Generic drug (Tier 1) $30 copay – Preferred Brand (Tier 2) $45 copay – Non-preferred Brand (Tier 3)	
100% AB		100% AB	
100% AB		100% AB	

* Precertification required or penalties may apply.
** Mandatory generic substitution—see the CareFirst Drug Program section on page 21.

CareFirst Drug Program Summary of Benefits

Formulary 2

Plan Feature	BlueChoice HMO Open Access	Triple Option	PPO CORE	Description
Deductible	None	None	None	Your benefit does not have a deductible.
Prescription Drug Out-of-Pocket Maximum	$6,600 Individual/ $13,200 Family	$5,400 Individual/ $10,800 Family	$4,200 Individual/ $8,400 Family	Your benefit does not have a family deductible maximum.
Preventive Drugs (up to a 34-day supply)	$0 (not subject to deductible)	$0 (not subject to deductible)	$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy & Diabetic Supplies (up to a 34-day supply)	$0	$0	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$10	$15	$15	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$20	$30	$30	All preferred brand drugs are covered at this copay level.
Non-Preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$40	$45	$45	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Maintenance Copays (up to a 90-day supply)				Maintenance medication must be purchased at a CVS pharmacy or through Mail Service for a 90-day supply.
Retail (CVS only):				
Generic	$20	$15	$15	
Preferred	$40	$30	$30	
Non-preferred	$80	$45	$45	
Mail Order:				
Generic	$20	$15	$15	
Preferred	$40	$30	$30	
Non-preferred	$80	$45	$45	
Prior Authorization	Some prescription drugs require Prior Authorization. Prior Authorization is a tool used to ensure that you will achieve the maximum clinical benefit from the use of specific targeted drugs. Your physician or pharmacist must call (800) 294-5979 to begin the prior authorization process. For the most up-to-date prior authorization list, visit the prescription drug website at **carefirst.com/rxgroup**.			
Mandatory Generic Substitution	If you choose a Non-preferred Brand drug (Tier 3) instead of its Generic equivalent, you will pay the highest copay plus, the difference in cost between the Non-preferred Brand drug and the Generic. If a Generic version is not available, you will only pay the copay.			

Plan Benefit Highlights for: Harford County Public Schools

Group No: 00528 - PPO – Comprehensive

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	Delta Dental PPO dentists: $25 per person / $50 per family each plan year Non-Delta Dental PPO dentists: $50 per person / $150 per family each plan year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,500 per person each plan year			
D & P counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	65 %
Surgical Removal of Impacted Teeth	100 %	65 %
Basic Services Fillings, denture repair/relining, stainless steel crowns, bridges, bridge recementation/repair and posterior composite restorations	80 %	50 %
Endodontics (root canals) Covered Under Basic Services	80 %	50 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	50 %
Oral Surgery Covered Under Basic Services	80 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	30 %
Prosthodontics Dentures	50 %	30 %
Implants Covered only as an alternative to a fixed bridge	80 %	50 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %
Orthodontic Maximums	$800 Lifetime	$800 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_DDP (Rev. 4/17/2017)

Plan Benefit Highlights for: Harford County Public Schools
Group No: 00528 - PPO Plus Premier - Standard

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26		
Deductibles	$25 per person / $50 per family each plan year		
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes		
Maximums	$1,500 per person each plan year		
D & P counts toward maximum?	No		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings, stainless steel crowns and posterior composite restorations	100 %	100 %
Endodontics (root canals)	100 %	100 %
Oral Surgery	100 %	100 %
Periodontics (gum treatment)	0 %	0 %
Major Services Crowns, inlays, onlays and cast restorations	0 %	0 %
Prosthodontics Bridges and dentures	0 %	0 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania One Delta Drive Mechanicsburg, PA 17055	**Customer Service** 800-932-0783	**Claims Address** P.O. Box 2105 Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_DDP (Rev. 4/17/2017)

Benefit Plan Resources

For the most current information, please consult the providers' websites or contact Customer Services:

Important Resources	Member Services Telephone Number	Web or Claims Mailing Address	
CareFirst BlueCross BlueShield Medical Claims	800-628-8549	carefirst.com	Mailroom Administrator PO Box 14115 Lexington, KY 40512
Mental Health	800-245-7013	carefirst.com/mentalhealth	
CVS Caremark and Mail Order Pharmacy	800-241-3371	carefirst.com/rx	
Delta Dental	800-932-0783	deltadentalins.com	PO Box 2105 Mechanicsburg, PA 17055-2105
Flexible Benefit Administrators, Inc. (FBA)	800-437-3539	flex-admin.com https://fba.wealthcareportal.com	
KEPRO (EAP)	866-795-5701	EAPHelplink.com; company code—HCPS	
State Retirement Agency	800-492-5909	sra.state.md.us	
Lincoln Financial Tax Deferred Compensation Plan (457b) (403b)	800-234-3500 Press "Ø"	hcps.org/departments/humanresources/benefits/retirement.aspx lincolnfinancial.com	
Harford County Public Schools Benefits Office	410-588-5275		
Benelogic	844-796-4086	https://hcps.benelogic.com	
Employee Incentives		https://hcps365.sharepoint.com/sites/HumanResources/Staffing/RecruitmentandRetention/default.aspx	