

2006-2007 PLAN YEAR
County Of San Diego — Comparison Of Medical Plans

Benefit	Managed Care Plans			Kaiser
	PacifiCare of California			
Twice-Monthly Cost <ul style="list-style-type: none"> • Employee Only • Employee + 1 Dependent • Employee + 2 or More Dependents 		\$ 172.06 \$ 344.16 \$ 486.90		\$ 152.37 \$ 304.74 \$ 431.21
	HMO Network <i>PCP Referred</i> (within medical group)	PPO Network <i>Self-Referred</i> (within PacifiCare PPO network)	Out-of-Network <i>Self-Referred</i> (outside PacifiCare network)	
Choice of Provider	Must receive services from PCP or be referred by PCP to specialist within the same medical group. You pay the lowest costs when you use this level under the Point of Service Plan.	May obtain care directly from any PacifiCare PPO Network Provider. You pay more for care when you use this level under the Point of Service Plan.	May obtain care from any other provider. However, you pay the highest costs when you use this level under the Point of Service Plan.	Your choice of Kaiser Permanente physicians and providers.
Annual Deductible* <ul style="list-style-type: none"> • Individual • Maximum per Family 	None None	\$300 per Person \$900 per Family		None None
Annual Out-of-Pocket Maximum (excludes deductible)	\$1,500 per individual \$3,000 per family	\$3,000 per individual \$6,000 per family	\$6,000 per individual \$12,000 per family	\$1,500 per individual \$3,000 per family
Lifetime Maximum	Unlimited	\$5,000,000.		Unlimited
Eligible Charges	N/A	N/A	Usual and customary rate (UCR)	N/A
Out-of-Hospital Services <ul style="list-style-type: none"> • Office Visits <ul style="list-style-type: none"> **Non-SVA Provider • Preventive Care <ul style="list-style-type: none"> Children 17 and Under **Non-SVA Provider Well-Woman Care <ul style="list-style-type: none"> **Non-SVA Provider Other Adult Health Evaluations <ul style="list-style-type: none"> **Non-SVA Provider • Outpatient Surgery • X-ray and Lab • Durable Medical Equipment 	You pay \$15 per visit You pay \$35 per visit • You pay \$15 per visit You pay \$35 per visit • You pay \$15 per visit You pay \$35 per visit • You pay \$15 per visit You pay \$35 per visit Plan pays 100% Plan pays 100% Plan pays 100%	Plan pays 80% after deductible • Plan pays 80% after deductible • Plan pays 80% after deductible • Not covered Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible • Plan pays 60% after deductible • Plan pays 60% after deductible • Not covered Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible	You pay \$15 per visit (You pay \$5 per visit to Pediatric physician) Routine physical exams for all members \$5 \$15 copay Plan pays 100% Plan pays 100%
In-Hospital Services <ul style="list-style-type: none"> • Semiprivate Room and Board • Emergency Room 	Plan pays 100% You pay \$35, waived if admitted; nonemergency use of emergency room not covered	Plan pays 80% after deductible; precertification required or penalty of 50% applied You pay \$35, waived if admitted; nonemergency use of emergency room not covered	Plan pays 60% after deductible; precertification required or penalty of 50% applied You pay \$35, waived if admitted; nonemergency use of emergency room not covered	Plan pays 100% You pay \$35, waived if admitted; non-emergency use of emergency room not covered
Skilled Nursing Facility	Plan pays 100%; maximum 100 days per year	Plan pays 80% after deductible precertification required or 50% penalty applied Maximum 60 days per year and inpatient days combined	Plan pays 60% after deductible; precertification required or penalty of 50% applied	Plan pays 100% up to 100 days per plan year***
Mental Health *** <ul style="list-style-type: none"> • Outpatient Visits (per policy year****) • In-Hospital Care (per policy year****) 	You pay \$15 per visit Plan pays 100%	Plan pays 50% of Contracted Rate Plan pays 50% of Contracted Rate	Plan pays 50% of UCR Plan pays 50% of UCR	You pay \$15 per visit; maximum 20 visit per plan year Plan pays 100% maximum 30 days per plan year
	Maximum 20 visits per year combined			
	Maximum 30 days per year combined Precertification required; combined for all levels			
Serious Mental Illness *** (as defined by California AB88) <ul style="list-style-type: none"> • Outpatient Visits (per policy year****) • In-Hospital Care (per policy year****) 	You pay \$15 per visit No maximum Plan pays 100% No maximum	Not Covered		You pay \$15 per visit No maximum Plan pays 100% No maximum
Substance Abuse *** <ul style="list-style-type: none"> • Outpatient Visits & In-Hospital Care 	Plan pays 100%	Plan pays 50% of Contracted Rate	Plan pays 50% UCR	\$15 per visit outpatient-Individual \$5 per visit outpatient-Group Plan pays 100% inpatient for detoxification 60 days maximum per year
	Annual Maximum \$25,000 combined Lifetime Maximum of \$35,000 combined			
Prescription Drugs (includes oral contraceptives)	Formulary Generics: You pay \$10 per prescription Formulary Brand Names: You pay \$20 per prescription At participating pharmacies Per 30 Day Supply		You must use PacifiCare-contracted pharmacies	You pay \$10 per Generic \$20 Brand at Kaiser Permanente pharmacies up to 100-day supply
Mail Order Drug Program	Formulary Generics: You pay \$20 per prescription Formulary Brand Names: You pay \$30 per prescription For maintenance drugs Per 90 Day Supply		You must use PacifiCare-contracted mail order drug	Up to 100-day supply for 1 copay \$10.00 Generic \$20.00 Brand

* All references to "annual" and "per year" on this chart refer to policy year of October through September 30.
** Scripps Clinic-San Diego is currently the only Non-SVA (Signature Value Advantage) provider.
*** Charges must be for treatment for conditions your physician believes are subject to improvement. Number of visits is determined by a physician.
**** Long-term/chronic conditions excluded.

**2006-2007 PLAN YEAR
County Of San Diego — Comparison Of Dental Plans**

Benefits	Indemnity Dental Plan		Prepaid HMO Dental Plans	
	SDC Dental Plan		PacifiCare Dental Plan 130	SafeGuard Dental Plan (Gemini 40)
Twice-Monthly Cost				
• Employee Only	\$ 23.83		\$ 7.94	\$ 7.99
• Employee +1 Dependent	\$ 47.65		\$ 14.35	\$ 14.67
• Employee + 2 or More Dependents	\$ 68.06		\$ 18.40	\$ 18.90
Choice of Dentist (USA only)	Any dentist you wish. Plan pays higher benefits if you use a preferred provider		Your choice of PacifiCare HMO dentist	Your choice of SafeGuard HMO dentist
Annual Deductible*	\$50 per individual \$150 maximum per family		None	None
Annual Maximum Benefit	\$1,500 per individual		None	None
Eligible Charges	Network providers: Negotiated fees Non-Network providers: Benefits based on usual, reasonable, and customary charges		All benefits based on charges authorized by the prepaid plan; all services by the dentist you have selected	
Preventive Services				
• Cleaning	Plan pays 100% 2x within 12 months 80% if Non-Network		No charge every 6 months	Covered 100% every 6 months
• Fluoride Treatment	Plan pays 100% 2x per plan year for children under age 16; 80% if Non-Network		Covered 100% every year for children to age 18 only	Plan pays 100% once per year for children to age 18 only
• Sealant Treatment	Plan pays 100% for children under age 16 for permanent molars every 5 years 80% if Non-Network		You pay \$5 per Tooth for children to age 18 only	You pay \$6 per tooth to age 14 (1 st and 2 nd permanent molars)
• Space Maintainer	Plan pays 100%; 80% if Non-Network		You pay \$10	You pay up to \$35
• X-rays (routine bite-wings)	Plan pays 100% per plan year; 80% if Non-Network		No charge every 6 months	Plan pays 100% per 12 mos.
Basic Services				
• Amalgam Filling	Plan pays 80%		You pay -0-	You pay -0-
• Resin - Silicate Fillings (3 Surfaces)	Plan pays 80%		You pay \$10 (Anterior only)	You pay \$10
• Simple Extraction	Plan pays 80%		You pay -0-	You pay -0-
• Full Bony Extraction	Plan pays 80%		You pay -0-	You pay \$50
• General Anesthesia	Plan pays 80%		Covered with limitations	Not covered
• Root Canal Therapy	Plan pays 80%		You pay \$35 per Root	You pay between \$45 to \$65
• Periodontal Maintenance	Plan pays 80%		You pay \$40 per quadrant	You pay \$15 per quadrant
• Periodontal Scaling & Root Planing/per Quadrant	Plan pays 80%		You pay \$40 per quadrant	You pay \$20
• Osseous Surgery	Plan pays 80%		You pay \$200 per quadrant	\$55 per quadrant
Major Services	<u>Network</u>	<u>Non-Network</u>		
• Most Crowns	Plan pays 70%**	60%	See Schedule of Benefits	You pay between \$50 - \$150 per crown (plus cost of precious/semi-precious metal)
• Denture Reline	Plan pays 70%	60%	You pay \$25	You pay \$30 (Chair side - You pay -0-)
• Complete or Partial Denture	Plan pays 70%**	60%	You pay \$70 per denture	You pay \$115 per full denture \$90 per partial denture
• Fixed Bridge	Plan pays 70%**	60%	See Schedule of Benefits	You pay \$70 per unit
Orthodontia Services (24-month banding)	Not covered except plan pays \$50 if Network orthodontist is used; this allows a network discount.		You pay \$1,695 plus all charges incurred before banding begins and after banding removal	You pay \$1,775 under age 20 and \$1,990 age 20 or over plus all charges incurred before banding begins, and after banding removal.

* All references to "annual" and "each year" on this chart refer to policy year of October 1 through September 30.

** Replacement bridges, crowns, and dentures are not covered unless they are over five years old and cannot be made serviceable. A fixed bridge is not covered if the carrier determines a partial fixture is satisfactory. Must be preauthorized. If your natural tooth is extracted or lost prior to this coverage, there is a three year waiting period.

**2006-2007 PLAN YEAR
County Of San Diego — Vision Plan**

Benefit	Vision Service Plan (VSP)
Twice-Monthly Cost	
• Employee Only	\$ 4.95
• Employee + 1 Dependent	\$11.44
• Employee + 2 or More Dependents	\$15.51
Choice of Provider	Any provider you wish. However the plan pays higher benefits if you receive care from a VSP provider. Over 300 VSP providers are available in San Diego County
Annual Deductible * (October 1 to September 30)	\$15 per individual
Eligible Charges	All benefits based on eligible charges
Annual Eye Exam	VSP provider: Plan pays 100% per plan year Other provider: Plan pays up to \$40 per exam per plan year
Lenses *	
• Standard Single Vision, Bifocal or Trifocal Glass or Plastic	VSP provider: Plans pays 100% for one pair per plan year Other provider: Contact plan for specific details
• Polycarbonate Lenses & Scratch Resistant Coating	
• Specialty, or Oversize	VSP provider: You pay additional laboratory cost plus small service fee over cost of standard lenses Other provider: You pay additional retail cost over the allowance
Frames *	VSP provider: Plan pays 100% of retail price up to \$130, every other plan year; you pay the difference of the amount over the retail price Other provider: Plan pays up to \$45; you pay retail price over \$45
Contact Lenses (benefit is in lieu of standard frames & lenses) *	
• Cosmetic	VSP provider: Plan pays 100% for exam and up to \$105 for contact lens fitting, evaluation and materials. Other Provider: Plan pays up to \$40 for exam and up to \$105 for contact lens fitting, evaluation and materials.
• Medically necessary	
• Laser Eye Surgery	VSP provider: Plan pays 100% per plan year Other Provider: Plan pays up to \$40 for exam and up to \$210 for contact lens fitting, evaluation and materials. \$500 per Eye per Lifetime

* Vision plans will cover lenses or contacts each year, and frames once every 24 months.

NOTE: 1. Call VSP Customer Service at (800) 622-7444 or visit the VSP web site at www.vsp.com for a list of member providers in your area. A participating provider will call VSP to verify your eligibility.
2. Additional glasses are available with a 20% discount at VSP providers.