ADMINISTRATIVE CIRCULAR NO. 40
Office of the Superintendent

SAN DIEGO CITY SCHOOLS

Date: October 21, 2005

To: All Employees in Paid Status in Monthly Salaried Positions

Subject: OPEN ENROLLMENT FOR MEDICAL/DENTAL PLANS

Department and/or Persons Concerned: All Employees in Paid Status in Monthly Salaried Positions

Due Date: November 30, 2005

Reference: None

Action Requested: Return Enrollment Form

Brief Explanation:

The annual medical/dental open enrollment period will be held November 1 through November 30, 2005. During this period eligible employees may enroll for medical and/or dental coverage if not currently enrolled, change enrollment to one of the other medical/dental plans being offered, and/or add eligible dependents not currently enrolled. **All open enrollment changes become effective January 1, 2006.**

It is very important that employees eligible for coverage read the accompanying information carefully and take timely action as appropriate**.** For your convenience, the attached open enrollment material may also be accessed via the Employee Benefits web site, **www.sandi.net/benefits**.

The PeopleSoft eBenefits module is now available on-line. eBenefits is an extension of the HR employee self-service offerings. You can view your healthcare elections, dependent/beneficiary information, and flexible spending account contributions. During the month of November 2005, you will also be able to make open enrollment changes on-line. Instructions for doing so are included on page 8 and 9 of the attached materials.

Medical/Dental Plans Offered for 2006

MEDICAL	**DENTAL**
PacifiCare HMO	**SDCS Dental**
PacifiCare POS (Point of Service)	**SafeGuard**
Kaiser	**Western Dental**

Please remember that except as indicated in the "Additional Information" section on page 5 of the attached material, once this enrollment period is closed, you will not have the opportunity to make additional changes until the next open enrollment period scheduled for November 2006.

PLEASE NOTE THE FOLLOWING VERY IMPORTANT INFORMATION:

During the month of November, every employee will be receiving a **"Certificate of Creditable Coverage".** Please read the following criteria to see what action you need to take:

- **If you or your dependent has reached age 65:** If you are on Medicare or have a dependent on Medicare, you must **KEEP** this certification in your permanent, personal files. As long as you are in a VEBA program, **DO NOT** apply for one of the Medicare Part D programs for your prescription drugs. **However**, should you ever leave the VEBA program to purchase an individual plan, you **will be required** to provide Medicare with copies of each and every certificate of creditable coverage that you received from VEBA, prior to being able to enroll in any other Medicare Part D program.
- **If you are age 64:** You need to start saving each and every one of the annual certifications from this point forward.
- **If you are under 64 but have a disabled dependent receiving Medicare:** You must **KEEP** this certification in your files. As long as you are in a VEBA program, **DO NOT** apply for one of the Medicare Part D programs for your prescription drugs. **However**, should you ever leave the VEBA program to purchase an individual plan, you **will be required** to provide Medicare with copies of each and every certificate of creditable coverage that you received from VEBA, prior to being able to enroll in any other Medicare Part D program.

If you need additional information or have any uncertainty about your employee/dependent enrollment status, please contact the Employee Benefits Office located in Room 1150-A at the Eugene Brucker Education Center. The telephone number is (619) 725-8130, option 6.

Ruth G. Peshkoff
Chief Human Resources Officer

APPROVED:

Carl A. Cohn
Superintendent of Schools

CAC:fr

Attachment

Distribution: List G

ANNUAL OPEN ENROLLMENT PERIOD
NOVEMBER 1–30, 2005

The annual open enrollment period will be held November 1 through November 30, 2005. During this period, eligible employees may enroll for medical/dental coverage, change plans, and/or add eligible dependents. All open enrollment changes will become effective January 1, 2006. Please study the following information very carefully, including the "Summary of Medical Benefits Plans" and the "Summary of Dental Benefits Plans," to determine which of the medical/dental plans offered best meets your needs and the needs of your family. You can also have your questions addressed directly by our medical and dental providers at one of the school site meetings the first week of November. Please contact your school secretary or assistant for a schedule of the meetings.

Medical/Dental Plans Offered for 2006:

MEDICAL	DENTAL
PacifiCare	**SDCS Dental Plan**
PacifiCare (Point of Service)	**SafeGuard**
Kaiser	**Western Dental**

Medical Plan Changes:

There have been no changes to the district's three medical plans for the 2006 calendar year. However, **there has been a change to the Prescription Drug coverage for PacifiCare. The HMO program for retail is now $5/$5/$20 with coordinating increases for the Medco by Mail. The POS has been changed to a $5/$10/$25 with coordinating increases for Medco by Mail. Please review the enclosed Benefit Plan Summaries.**

Dental Plan Changes:

There have been no changes to the either the SafeGuard or Western dental plans for the 2006 calendar year. However, **please be advised that there has been a change to the reimbursement of out-of-network providers on the San Diego City Schools dental plan.** Please carefully review the dental plan summary enclosed.

OPEN ENROLLMENT TIMELINES AND PROCEDURES

No enrollment forms are necessary unless you wish to make some type of change. If you have any uncertainty about your employee/dependent enrollment status, please call the Employee Benefits Office at (619) 725-8130, option 6.

To enroll for coverage, change plans, or enroll eligible dependents, employees must complete and submit appropriate enrollment forms to the Employee Benefits Office, no later than **Wednesday, November 30, 2005**.

The **PeopleSoft eBenefits** module is now available on-line. **eBenefits** is a self-serve application which allows you to view your healthcare elections, dependent/beneficiary information, and flexible spending account contributions. During the month of November, 2005, you will also be able to make open enrollment changes on-line. Instructions for signing into PeopleSoft and changing your password are included in this booklet. You can find additional self-help materials at: *http://prod031.sandi.net/dwa/dwa_training_peoplesoft_hr_materials.htm*

If you do not have access to a personal computer with Internet capability, you may enroll by completing the appropriate forms available at each school site, the Employee Benefits Office or at the scheduled open enrollment meetings.

After completing your benefit/personal information selections and or changes on-line, you will receive a confirmation letter from the Employee Benefits Office. Please **immediately** review the information for accuracy and contact the Employee Benefits Office within **seven (7) calendar days** of the date of the letter with any corrections. **If you have made a carrier change on-line, you must complete the appropriate enrollment form and forward it to the Employee Benefits Office prior to December 1, 2005. It is an employee's responsibility to ensure that the properly completed enrollment forms are received in the Employee Benefits Office no later than November 30, 2005**. Forms received after this date cannot be processed.

If you have enrolled on-line and do not receive a confirmation letter with in seven (7) working days, please contact the Employee Benefits Office at (619) 725-8130 option 6.

ELIGIBILITY

Employees eligible for **medical, dental and vision** coverage are:

- All employees in paid status in monthly salaried positions of half-time or more and employees in job-share assignments. (Employees in job-share assignments must pay a pro-rata share of the cost, if coverage is desired.)

Eligible Dependents are:

- An eligible employee's legal spouse who has not entered a final decree of divorce or an annulment from the employee and is not on active duty as a member of the armed forces, or an unmarried employee's same-sex domestic partner who is not on active duty as a member of the armed forces and is not legally married to another individual.

- An eligible employee's unmarried child (including any stepchild, child of the employee's same-sex domestic partner, legally adopted child, or child for whom the employee is named

legal guardian by court order) who has not attained his/her nineteenth birthday, is not covered for benefits as an employee, and is not on active duty as a member of the armed forces.

- An eligible employee's unmarried child (including any stepchild, child of the employee's same- sex domestic partner, legally adopted child, or child for whom the employee is named legal guardian by court order) who is at least nineteen years of age, but less than twenty-five years of age, is primarily dependent upon the employee for support and maintenance, and attends an accredited college, university, or vocational/technical school as a full-time student[1]. The vocational/technical school must be approved by the State Department of Education.

- An eligible employee's unmarried child (including any stepchild, child of the employee's same-sex domestic partner, legally adopted child, or child for whom the employee is named legal guardian by court order) who is at least nineteen years of age, is primarily dependent upon the employee for support and maintenance, and is incapable of self-sustaining employment because of mental retardation or physical handicap and has been medically certified as totally disabled prior to age nineteen.[2]

DISTRICT PAID
PLAN COSTS FOR 2006

Employees Half-Time or More:

No employee contribution will be required for medical, dental or vision coverage during 2006 for employees in paid status in monthly salaried positions of half-time or more (excluding employees in job-share assignments). The district pays the full cost of coverage as indicated below:

Plan	Annual Cost
Kaiser	$7,277.16
PacifiCare HMO	$7,881.72
PacifiCare POS	$9,131.52
SDCS Dental	$ 773.50
SafeGuard	$ 298.80
Western Dental	$ 343.92
Vision Service Plan	$ 88.50

[1] Full-time student certification must be provided to the VEBA administrator twice each year (September and January).
[2] Handicapped child certification must be provided when requested by the VEBA administrator.

Job-Share Employees:

Employees in job-share assignments who are enrolled for medical, dental and/or vision coverage may be required to pay a pro-rata share of the cost of coverage on a tenthly basis (September through June) through payroll deduction. Please note that dental and vision coverage cannot be canceled mid-year. An active job-share employee who wishes to participate in a dental and/or vision plan must continue to make the required tenthly pro-rata contribution through the end of the calendar year. Contact the Employee Benefits Office for pro-rata rates. (A pro-rata share of the cost of coverage may not be applicable to a job-share employee who has been assigned his/her partner's percentage of participation.)

HOW TO OBTAIN INFORMATION ABOUT THE PLANS

The following sources are available for employees to obtain information about the medical and dental plans being offered for 2006.

- Brief summaries comparing the major benefits of each of the medical plans and each of the dental plans are provided on pull-out sheets in the center of this packet.
- Open enrollment material may be accessed via the Employee Benefits website, **www.sandi.net/benefits**.
- A small supply of provider directories for the PacifiCare plans and each of the dental plans has been sent to school site secretaries. These directories are also available from the Employee Benefits Office located in Room 1150-A at the Eugene Brucker Education Center, (619) 725-8130, option 6.
- Some of the plans have provider directories available on websites. For those which do, the website address is indicated below.
- The telephone numbers and website addresses listed below may be used to obtain information about each plan's benefits and participating providers.

MEDICAL

PacifiCare
HMO (800) 624-8822
POS (800) 913-9133
www.pacificare.com

Kaiser Health Plan
Benefits/Provider Network (800) 464-4000
www.kaiserpermanente.org/locations/california

CHIROPRACTIC BENEFITS

American Specialty Health Plans (ASH Plan) (800) 678-9133
www.ashcompanies.com

MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS (for PacificCare plans):

PacifiCare Behavioral Health (888) 625-4809

PHARMACY (for PacificCare plans)

Medco Health Solutions, LLC (800) 918-8011
www.medcohealth.com

DENTAL

San Diego City Schools Dental Benefits Plan
Benefits Eligibility Information (619) 725-8130, option 6
Provider Network (800) 247-2898
www.ccnusa.com/sdcs/dental.htm

SafeGuard Dental (800) 750-4303
www.safeguard.net

Western Dental (800) 992-3366
www.westerndental.com

VISION

Vision Service Plan (800) 877-7195
www.vsp.com

ADDITIONAL INFORMATION

Last Chance Until Next Year!

After this open enrollment period ends, except as indicated below, employees will **not** have the opportunity to enroll for coverage, change medical and/or dental plans, or to add eligible dependents until the next open enrollment period during the month of November 2006.

Enrollment changes allowable outside the annual open enrollment period are as follows:

- Newly eligible employees (i.e., changing from less than half-time to half-time or more assignments or returning from long-term, unpaid leave of absence) may enroll for coverage by submitting appropriate enrollment forms to the Employee Benefits Office **within 31 days of becoming eligible**.

- Newly eligible dependents (i.e., marriage, birth, adoption, or placement for adoption) may be added to your coverage by submitting appropriate enrollment forms to the Employee Benefits Office **within 31 days of the event**.

- When an employee or a dependent does not enroll for district medical coverage because he/she has other coverage, a federal law known as HIPAA permits enrollment at times other than open enrollment when loss of the other coverage occurs. An appropriate enrollment application must be submitted to the Employee Benefits Office **within 31 days following the loss of other coverage**. This special enrollment provision also allows an employee to enroll for coverage for self/dependents **within 31 days of acquiring a new dependent** (i.e., marriage, birth, adoption, or placement for adoption).

Changing Plans:

- For employees changing medical plans or enrolling for medical coverage for the first time, if the employee or dependent is confined in a hospital or skilled nursing facility on January 1, 2006, notification must be made to the new plan: Kaiser (800) 464-4000, PacifiCare HMO (800) 624-8822, or POS (800) 913-9133, as applicable, on or before January 1, 2006**. Failure to make notification could result in a reduction or loss of benefits.**

Continuation Coverage:

- Under a federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act), an employee and/or a covered dependent who ceases to be eligible for coverage under district-sponsored health plans because of certain "qualifying events" (such as termination of employment, divorce, loss of full-time student status, etc.), may continue coverage for a limited period of time on a self-pay basis. Contact the Employee Benefits Office for information.

- Eligible employees who separate from the district by reason of retirement may elect to continue coverage on a self-pay basis under a district-sponsored medical and/or dental plan for themselves and their legal spouse (medical coverage may be continued for eligible children also). Eligible employees are those employees who are covered under a district-sponsored medical/dental plan immediately prior to their retirement effective date with the Public Employees' Retirement System (PERS) or the State Teachers' Retirement System (STRS) and who will be receiving a monthly benefit under either of these retirement systems. For retiring employees who meet certain additional requirements, the district makes a contribution toward the cost of medical coverage.

- Temporary, Interim, Emergency and Leave Replacement employees who work a traditional schedule (10 mos.) whose coverage ends at the end of the month of the last day of the school year. You and your covered dependents are eligible for COBRA coverage. Please contact the Employee Benefits Office if you would like to continue your coverage.

If additional information is needed, please contact the Employee Benefits Office located in Room 1150-A of the Eugene Brucker Education Center. The telephone number is (619) 725-8130, option 6.

Setting Up Your DWA Password

Before you can begin to use any San Diego City Schools PeopleSoft applications you need to set up your DWA (District Wide Applications) password. First you must launch Microsoft Internet Explorer. Then:

1. Go to **https://dwa.sandi.net/passwd** as shown below.

dwa SAN DIEGO CITY SCHOOLS

DWA Password Change

Use this page to change your DWA Password for the following applications: PeopleSoft, Zangle, Outlook Web Access.

If you have never logged in with this account, your default password will be "Sdcs" followed by the last four digits of your SSN (Sdcs1234). Your default password must be changed to a permanent one using the **Password Format** listed below, prior to your initial login to the listed applications. Please note that passwords are CASE SENSITIVE.

Employee ID:		(Your 6-digit Employee ID)
Current Password:		(Current password or default password)
New Password:		(Follow the Password Format below)
Re-enter New Password:		

OK Cancel Reset

PASSWORD FORMAT:

- Must be a minimum 8 characters;
- Must contain at least one CAPITAL letter and one lowercase letter;
- Must contain at least one number (0-9);
  Cannot contain your first or last name or your DWA ID;

NOTE: Never provide your default password or newly selected password to anyone either by phone, email, or in person. Also, do not record your password and leave it at your workstation. You are responsible for the integrity of your password.
If you have questions about the password change screen, please contact the Help Desk at 619-725-7500.

2. Carefully read and follow the instructions on the next screen you see. There are four blank fields you must complete as follows:
   a) **Employee ID:** Enter your SDCS Employee ID number. (If you don't know it, look on your paycheck stub).
   b) **Current Password:** Your "default" password (which is case sensitive) to begin with is: **Sdcs_ _ _ _.** The four blank spaces after Sdcs are the last four digits of your own Social Security number.
   c) **New Password:** You must create and enter a new personal password. It must contain a minimum of eight characters, to include one capital letter and one numeral. You cannot use your name. An example might look like this: Teacher5
   d) **Re-enter New Password:** Re-enter the password you just created. Be sure to write it down! If you forget your new password, you will have to contact the IT Help Desk.
3. Click the **OK** button. (*Please turn to other side of this Job Aid*).

Use this page to change your DWA Password for the following applications: PeopleSoft, Zangle, Outlook Web Access.

If you have never logged in with this account, your default password will be "Sdcs" followed by the last four digits of your SSN (Sdcs1234). Your default password must be changed to a permanent one using the **Password Format** listed below, prior to your initial login to the listed applications. Please note that passwords are CASE SENSITIVE.

Employee ID:	123456	(Your 6-digit Employee ID)
Current Password:	********	(Current password or default password)
New Password:	********	(Follow the Password Format below)
Re-enter New Password:	********	

OK Cancel Reset

4. The next screen you see should be a confirmation that your password was “changed” successfully. If that is the case, you are finished and you can log out of the DWA web site. If that is not the case, (if you get a message saying there is an error or incorrect information, for example) then you must contact the **IT Help Desk** at **(619) 725-7500** and ask them to reset your DWA password.

The chart shown below is informational for your convenience.

Initial Password	User must change at next logon
Enforce Password History	6 passwords
Minimum Password Age	24 hours
Minimum Password Length	8 characters
Account Lockout Threshold	6 invalid logon attempts
Reset Account Lockout After	15 minutes

Initial Password: This is your “default” password (Sdcs_ _ _ _) that you need to change to a personal password the first time you log on.

Enforce Password History: Each time the system requires you to change your password (every 90 days) you must use a different password for each of six consecutive changes. On the seventh password change you can start to use the same password again that you used for the very first time, if you wish.

Minimum Password Age: The minimum amount of time you must use any password you create. In other words, once you change a password, you cannot go back and change it again that same day. You must wait 24 hours.

Minimum Password Length: The fewest number of characters required to create a password. You must have a minimum of 8 characters (a character can be a numeral or a letter) in your password.

Account Lockout Threshold: If you make six consecutive attempts to log in and all of those attempts fail (usually this happens when you forget your password and you keep trying different versions of it), the system will lock you out and not let you log on again for 15 minutes.

Reset Account Lockout After: After six failed log on attempts in a row, the system makes you wait 15 minutes before you can try to log on again.

SAN DIEGO CITY SCHOOLS
VOLUNTARY EMPLOYEE BENEFITS ASSOCIATION (VEBA)
SUMMARY OF MEDICAL BENEFITS PLANS
2006 PLAN YEAR

January 1, 2006

		PacifiCare HMO 5	PacifiCare POS B10 (Point of Service)		KAISER PERMANENTE 0/5
			IN-NETWORK	OUT-OF-NETWORK	
1. TYPE OF PLAN		A Health Maintenance Organization (HMO). The member must select a PacifiCare Primary Care Physician (PCP) who coordinates all their medical care, including medically necessary referrals to specialists associated with the PCP's medical group. To participate in this Plan, members must live within PacifiCare's service area. Exception: for eligible dependent children residing outside of PacifiCare's HMO network, see item #24. This Plan provides benefits only for covered services and supplies which are medically necessary as determined by PacifiCare.	The POS B10 Plan is similar to the HMO 5. A member must live within a service area. Exception: for eligible dependent children residing outside of a HMO network, see item #24. A member must select a Primary Care Physician (PCP) who coordinates all their In-Network medical care, including medically necessary referrals to specialists associated with the PCP's medical group. However, the POS B10 Plan offers additional flexibility which allows the member to choose between their contract provider or any other licensed health care provider (not affiliated with their PCP), each time they seek medical care. When Out-of-Network providers are used, lower benefits are received, annual deductibles must be met, and claim forms are required for reimbursement of Covered Expenses. This Plan provides benefits only for covered services and supplies which are medically necessary as determined by PacifiCare. Healthcare benefits for some services are provided in-network only.	The POS B10 Plan is similar to the HMO 5. A member must live within a service area. Exception: for eligible dependent children residing outside of a HMO network, see item #24. A member must select a Primary Care Physician (PCP) who coordinates all their In-Network medical care, including medically necessary referrals to specialists associated with the PCP's medical group. However, the POS B10 Plan offers additional flexibility which allows the member to choose between their provider or any other licensed health care provider (not affiliated with their PCP), each time they seek medical care. When Out-of-Network providers are used, lower benefits are received, annual deductibles must be met, and claim forms are required for reimbursement of Covered Expenses. This Plan provides benefits only for covered services and supplies which are medically necessary as determined by PacifiCare. Healthcare benefits for some services are provided in-network only.	A federally qualified Health Maintenance Organization (HMO) offering comprehensive health care service. To participate in this Plan a member must live in a Kaiser Permanente approved service area. The services of the Plan must be prescribed or authorized by a Kaiser Permanente physician or other Kaiser health care professional. Services are subject to review by the Plan for medical necessity determination. Each family member may select a different PCP and/or medical office.
2. CHOICE OF PROVIDER		Each person enrolled in the Plan is required to select a PCP from the Provider Directory. Each family member may select a different PCP and/or Medical Group. Outpatient Prescription Drugs and Medications must be obtained through a participating Medco Health retail pharmacy or Medco By Mail service. Mental Health/Substance Abuse benefits are provided through PacifiCare Behavioral Health. Chiropractic benefits are provided through American Specialty Health Plans (ASH Plans).	Each person enrolled in the Plan is required to select a PCP from the Provider Directory. Each family member may select a different PCP and/or Medical Group. Outpatient Prescription Drugs and Medications must be obtained through a participating Medco Health retail pharmacy or Medco By Mail service. Mental Health/Substance Abuse benefits are provided through PacifiCare Behavioral Health. Chiropractic benefits are provided through American Specialty Health Plans (ASH Plans).	Except for Outpatient Prescription Drugs and Medications, Chiropractic Benefits, and Mental Health/Substance Abuse benefits, members may use any licensed provider worldwide.	Members are encouraged to select a personal physician from the Kaiser Permanente staff and choose a medical office that is convenient to home or office. Services, except for emergency care in some cases, are available only at Kaiser Permanente medical offices and hospitals. For locations and telephone numbers, consult the benefits brochure available from Kaiser Permanente Member Services. Chiropractic benefits are provided through American Specialty Health Plans (ASH Plans).
3. BENEFIT PERCENTAGE PAYABLE		Plan pays 100% after required member copays indicated in this Summary and the benefits brochure.	Plan pays 100% after required member copays indicated in this Summary and the benefits brochure.	After required Deductibles, the Plan will pay a percentage of UCR* charges for covered services and supplies that are determined by the Plan to be medically necessary. In most cases the Benefit Percentage is 80%; however, after the out-of-pocket maximum described in item #5 is reached, the Benefit Percentage will increase for the remainder of the calendar year to 100% of UCR* charges.	Plan pays 100% after the required copays indicated in the summary and the benefits brochure.
4. ANNUAL PLAN YEAR DEDUCTIBLES	a. Individual	None	None	$250 per calendar year.	None
	b. Family	None	None	$750 per calendar year.	None
5. PLAN YEAR OUT-OF-POCKET LIMIT (Excludes Deductible)	a. Individual	$800 per calendar year. See note in #5b below.	$800 per calendar year. See note in #5b below.	$3,000 per calendar year. See note in #5b below.	$1,500 per calendar year. See note in #5b.
	b. Family	$2,400 per calendar year. Note: Out-of-Pocket expenses and copays for Chiropractic care, Outpatient/Out-of-Hospital Prescription Drugs and Medications, and Mental Health/Substance Abuse, are not applied to the Out-of-Pocket Limit.	$2,400 per calendar year. Note: Out-of-Pocket expenses and copays for Chiropractic care, Outpatient/Out-of-Hospital Prescription Drugs and Medications, and Mental Health/Substance Abuse are not applied to the Out-of-Pocket Limit.	$6,000 per calendar year. Note: Out-of-Pocket expenses and copays for Inpatient Hospital, Chiropractic care, Mental Health/Substance Abuse and Outpatient/Out-of-Hospital Prescription Drugs and Medications are not applied to the Out-of-Pocket Limit.	$3,000 per calendar year. Note: Out-of-Pocket expenses and copays for Chiropractic care are not applied to the Out-of-Pocket Limit.
6. HOSPITAL INPATIENT/ OUTPATIENT	a. Participating Provider	No charge	Member pays $200 per admission.	N/A	No charge
	b. Non-participating Provider	Not covered	Not covered	Plan pays 80% of UCR* charges: Note: The percentage payable will be reduced to 50% for medically necessary covered Out-of-Network services received for which preauthorization was not obtained. The additional amount a member is required to pay because preauthorization was not obtained will not be applied to the annual copayment maximum.	Not covered except emergencies as described in item #21.
	c. Mental Health/ Substance Abuse	See item #11.	See item #11.	See item #11.	See item #11.
	d. Emergency Room	$35 copay (waived if admitted). (Use of hospital emergency room in a non-emergency situation is not covered.)	$35 copay (waived if admitted). (Use of hospital emergency room in a non-emergency situation is not covered.)	Use of a hospital emergency room in an emergency situation, member pays $35 copay. Use of a hospital emergency room in a non-emergency situation is not covered.	No charge in a Kaiser facility. For a non-Kaiser facility, see item #21.
7. PHYSICIAN/SURGEON	a. Hospital Care	No charge	No charge	Plan pays 80% of UCR* charges.	No charge
	b. Office Care	Member pays a $5 copay for each visit.	Member pays $10 copay for each visit.	Plan pays 80% of UCR* charges.	No charge
	c. Well-Baby Care/ Immunizations	No charge up to 2 years old. $5 copay applies to infants that are ill at time of service	No charge up to 2 years old. $10 copay applies to infants that are ill at time of service.	Plan pays 80% of UCR* charges through age 2.	No charge
	d. Routine Physical Exam	Member pays a $5 copay for each visit.	Member pays $10 copay for each visit.	Plan pays 80% of UCR* charges. Benefits provided for dependent to age 18. Age 18 and above not covered.	No charge
	e. Mental Health/ Substance Abuse	See item #11.	See item #11.	See item #11.	See item #11.
	f. Therapeutic Injections	Member pays a $5 copay for each visit.	Member pays $10 copay for each visit.	Plan pays 80% of UCR* charges.	No charge
	g. Routine Mammogram	No charge	No charge	Plan pays 80% of UCR* charges. Subject to age-related schedule.	No charge
8. X-RAY & LAB		No charge	No charge	Plan pays 80/100% of UCR* charges.	No charge
9. OUTPATIENT/OUT-OF-HOSPITAL DRUGS AND MEDICINES		Must use a participating Medco Health retail pharmacy or Medco By Mail. Member is responsible for the following copays: Medco retail pharmacy network* (up to 30-day supply) / Medco By Mail (up to 90-day supply) Generic: $5 / $10 Preferred brand name: $5 / $10 Non-preferred covered drugs: $20 / $40 **For selected maintenance medications you may fill your prescription plus two refills at the retail pharmacy copay. On the third and subsequent refills, you pay the Medco By Mail copay whether you purchase a 30-day supply at a retail pharmacy or a 90-day supply through Medco By Mail.* *A generic equivalent will be dispensed if one is available unless the physician indicates on prescription that the brand name is required. Brand-name drugs purchased because of personal preference, not medical necessity, will require that the member pay the difference between the cost of the brand-name drug and the generic drugs in addition to the copayment amount.*	Must use a participating Medco Health retail pharmacy or Medco By Mail. Member is responsible for the following copays: Medco retail pharmacy network† (up to 30-day supply) / Medco By Mail (up to 90-day supply) Generic: $5 / $10 Preferred brand name: $10 / $20 Non-preferred covered drugs: $25 / $50 *†For selected maintenance medications you may fill your prescription plus two refills at the retail pharmacy copay. On the third and subsequent refills, you pay the Medco By Mail copay whether you purchase a 30-day supply at a retail pharmacy or a 90-day supply through Medco By Mail.* *A generic equivalent will be dispensed if one is available unless the physician indicates on prescription that the brand name is required. Brand-name drugs purchased because of personal preference, not medical necessity, will require that the member pay the difference between the cost of the brand-name drug and the generic drugs in addition to the copayment amount.*	The greater of: 50% of the cost, or $10 for generic/$30 for preferred brand name/$60 for non-preferred covered drugs; each prescription limited to 30-day supply; Medco By Mail not available.	Prescription must be written by a Kaiser Permanente physician (or any licensed dentist) and obtained at a Kaiser pharmacy. Member pays $5 copay for each prescription or refill. Prescription refills are also available by mail. You may receive up to a 100-day supply of medications for the charge of one copayment at the pharmacy or by mail.

(Continued on other side)

	PacifiCare HMO 5	PacifiCare POS B10 (Point of Service)		KAISER PERMANENTE 0/5
		IN-NETWORK	OUT-OF-NETWORK	
10. CHIROPRACTIC BENEFITS	Not covered unless all services are obtained from ASH Plans. Members may access care and treatment by calling 1-800-678-9133. PCP referral is not required. Member pays $10 per visit, limited to 30 visits per calendar year.	Not covered unless all services are obtained from ASH Plans. Members may access care and treatment by calling 1-800-678-9133. PCP referral is not required. Member pays $10 per visit limited to 30 visits per calendar year.	Not covered.	Not covered unless all services are obtained from ASH Plans. Members may access care and treatment by calling 1-800-678-9133. PCP referral is not required. Member pays $10 per visit limited to 30 visits per calendar year.
11. MENTAL HEALTH/SUBSTANCE ABUSE	Not covered unless all inpatient and outpatient care is preauthorized by PacifiCare Behavioral Health and services obtained from PacifiCare Behavioral Health participating providers. PCP Referral is not required. Members may access care and treatment by calling 1-888-625-4809.	Not covered unless all inpatient and outpatient care is preauthorized by PacifiCare Behavioral Health and services obtained from PacifiCare Behavioral Health participating providers. PCP referral is not required. Members may access care and treatment by calling 1-888-625-4809.	Not covered.	Nine severe mental illness diagnoses (schizophrenia, schizo-affective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa, and bulimia nervosa) and serious emotional disturbances (SED) of children will be covered under the same terms and conditions as other medical conditions covered by the plan.
a. Inpatient 1) Mental Health	No charge	Member pays $200 copay per admission.		Non-mental health parity: $0 copay; up to 45 days per calendar year. Mental health parity: $0 copay; unlimited visits.
2) Substance Abuse and Detox	Member pays $25 copay per day; limited to 30 days per calendar year.	Member pays $250 copay each episode, limited to 2 treatment episodes per lifetime. Maximum of 30 days per calendar year.		Provided at $0 charge when medically necessary for detoxification only. Counseling and educational classes are available at time of detoxification.
b. Outpatient 1) Mental Health	Member pays $5 copay for each visit.	Member pays $10 copay for each visit. Unlimited visits.		Non-Mental Health Parity: $0 copay per visit; 20 visits per calendar year. Mental Health Parity: $0 copay; no visit limit.
2) Substance Abuse and Detox	Member pays no charge for visits 1-20; $20 copay each for visits 21-40; and $25 copay each for visits 41-60; limited to 60 visits per calendar year.	Member pays nothing for first 5 visits and $10 copay each visit thereafter.		$0 copayment per visit for both individual and group therapy.
12. OUTPATIENT OUT-OF-HOSPITAL PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	Member pays $5 copay each visit for medically-necessary rehabilitative therapy following injury, surgery, or medical conditions. Unlimited visits.	Member pays $10 copay per visit for medically-necessary rehabilitative therapy following injury, surgery, or medical conditions; unlimited visits.	Plan pays 80% of UCR* charges after deductible; limited to 60 consecutive days from first day of treatment for the condition.	No charge. Limited to conditions that are subject to significant improvement in function within a two-month period per condition.
13. SKILLED NURSING FACILITY	No charge; no visit limit	No charge; no visit limit	Plan pays 80% of UCR* charges after deductible; limited to 60 days per calendar year.	No charge for up to 100 days/calendar year.
14. HOME HEALTH CARE	No charge	No charge	Plan pays 80% of UCR* charges; maximum not to exceed 100 visits per calendar year.	No charge; requires prior authorization by Kaiser.
15. AMBULANCE	No charge when determined medically necessary by the Plan.	No charge when determined medically necessary by the Plan.	No charge when determined medically necessary by the Plan.	No charge for emergency transportation when authorized or approved by a Kaiser physician.
16. EYE EXAMS FOR REFRACTION	Member pays $5 copay. Coverage provided once each calendar year for eye examination only. Must use participating providers.	Member pays $10 copay. Coverage provided once each calendar year for eye examination only. Examinations must be obtained through PCP.	Not covered	No charge. Covers eye examinations only.
17. DURABLE MEDICAL EQUIPMENT	No charge. Subject to Plan limitations and exclusions.	No charge. Subject to Plan limitations and exclusions.	Plan pays 80% of UCR* charges. Subject to Plan limitations and exclusions.	No charge. Subject to Plan limitations and exclusions.
18. PROSTHETICS	No charge. Subject to Plan limitations and exclusions.	No charge. Subject to Plan limitations and exclusions.	Plan pays 80% of UCR* charges.	No charge. Subject to Plan limitations and exclusions.
19. TEMPEROMANDIBULAR JOINT (TMJ) TREATMENT/JAW JOINT TREATMENT	Dental treatment and orthodontic services and appliances are not covered. Non-dental treatment will be reviewed by the Plan for consideration.	Dental treatment and orthodontic services and appliances are not covered. Non-dental treatment will be reviewed by the Plan for consideration.	Dental treatment and orthodontic services and appliances are not covered. Non-dental treatment will be reviewed by the Plan for consideration.	Not covered
20. LIFETIME AGGREGATE MAXIMUM BENEFIT	No maximum	No maximum	$2,000,000	No maximum
21. URGENT MEDICAL CARE a. In-Network	Member pays $5 copay at PCP's medical group; otherwise #21b applies	Member pays $10 copay at PCP's medical group; otherwise #21b applies	N/A	Kaiser will pay the Usual, Customary, and Reasonable fee if injury or illness requires emergency care from non-Kaiser physicians and hospitals inside or outside the Service Area (See "Emergency Services" section of brochure).
b. Out-of-Network	Member pays a $35 copay for first visit; if certified by PCP	Member pays a $35 copay for first visit; if certified by PCP	Member pays a $35 copay for first visit; if certified by PCP	
22. MEDICARE	Payment of Medicare benefits may be impacted by enrollment in this plan. For information, call PacifiCare member services at 1-800-624-8822.	Payment of Medicare benefits may be impacted by enrollment in this plan. For information, call PacifiCare member services at 1-800-913-9133.	Payment of Medicare benefits may be impacted by enrollment in this plan. For information, call PacifiCare member services at 1-800-913-9133.	Payment of Medicare benefits may be impacted by enrollment in this plan. For information, call Kaiser Permanente member services at 1-800-464-4000.
23. PRE-EXISTING CONDITION LIMITATIONS	This Plan has no elimination period. See Plan Document for limitations and exclusions.	This Plan has no elimination period. See Plan Document for limitations and exclusions.	This Plan has no elimination period. See Plan Document for limitations and exclusions.	This Plan has no elimination period. See Plan Document for limitations and exclusions.
24. DEPENDENT CHILDREN RESIDING OUTSIDE NETWORK	Eligible dependents who live within another PacifiCare HMO service area can choose their own primary care physician (PCP) in their service area. Eligible dependents who live outside a PacifiCare HMO or POS service area are eligible for coverage through PacifiCare's Out-of-Area PPO/Indemnity plan. To find out which option applies to your dependent, call PacifiCare Member Services at 1-800-624-8822.	Eligible dependents who live within another PacifiCare POS/HMO service area can choose their own primary care physician (PCP) in their service area. Eligible dependents who live outside a PacifiCare POS service area are eligible for coverage through PacifiCare's Out-of-Area PPO/Indemnity plan. To find out which option applies to your dependent, call PacifiCare Member Services at 1-800-913-9133.	Eligible dependents who live within another PacifiCare POS/HMO service area can choose their own primary care physician (PCP) in their service area. Eligible dependents who live outside a PacifiCare POS service area are eligible for coverage through PacifiCare's Out-of-Area PPO/Indemnity plan. To find out which option applies to your dependent, call PacifiCare Member Services at 1-800-913-9133.	For information regarding eligible dependent children residing outside Kaiser Permanente's San Diego service area, please contact Customer Service Call Center at 1-800-464-4000. Special arrangements must be made with Kaiser Permanente to establish this coverage.

This summary is merely a brief comparison of the major benefits of each of the plans and is not intended to alter or expand your benefits rights or liabilities as set forth in the official Plan Document/Contracts. For further information on the above plans, refer to the individual plan brochures or contact one of the following as appropriate: PacifiCare Member Services HMO at 1-800-624-8822, POS at 1-800-913-9133, or Kaiser Permanente Member Services at 1-800-464-4000.

Selecting a health plan is an important and personal matter. Among the many factors which need to be considered are cost, level of coverage, convenience, service area, quality and number of physicians, hospitals, and other providers, and type of plan. There is no assurance that a particular provider will continue to participate in a specific plan or medical group. It is the patient's responsibility to verify that a particular provider is a participant in a plan prior to obtaining services or supplies.

UCR* means Usual, Customary, and Reasonable, as determined by PacifiCare and Kaiser.

San Diego City Schools

DENTAL PLAN COMPARISON

SAN DIEGO CITY SCHOOLS
SUMMARY OF DENTAL BENEFITS PLANS

January 1, 2006

	SAN DIEGO CITY SCHOOLS DENTAL BENEFITS PLAN	SAFEGUARD (formerly Health Net Dental)	WESTERN DENTAL
1. TYPE OF PLAN	A traditional insurance-type dental benefits plan, self-funded by the District with claims processing provided by The Plan Handlers, Inc.	An HMO-type prepaid dental plan. All services must be obtained from a SafeGuard provider.	An HMO-type prepaid dental plan. All services must be obtained from a Western Dental provider.
2. CHOICE PROVIDER	Each person enrolled in the Plan may select the services of any licensed dentist; however, dentists who are members of Community Dental Network (CDN) have agreed to accept the Plan's payment as payment in full for covered services subject to the Plan's deductibles, maximum benefits, limitations, and exclusions.	At the time of enrollment, each member must select a dentist or dental group which participates in the SafeGuard dental plan. Treatment must be provided by a participating dentist except for emergency situations. Certain services performed by a specialist are covered by the plan. Patients are treated by a specialist only upon referral by the primary care dentist.	At the time of enrollment, each member must select a dentist or dental group which participates in the Western Dental plan. Treatment must be provided by a participating dentist except for emergency situations. Certain services performed by a specialist are covered by the plan. Patients are treated by a specialist only upon referral by the primary care dentist.
3. DEDUCTIBLES	The Deductible is the amount of Covered Expenses which must be paid by a Covered Person before any benefits are payable for that person under any portion of the Plan. The Deductible is $25 per person per calendar year. There is a maximum Deductible of $75 per family per calendar year.	None	None
4. MAXIMUM BENEFIT	The Maximum Benefit which will be paid by the Plan is $1500 per person per calendar year; however, if a Covered Person is concurrently covered as an Employee and as the spouse or Domestic Partner of another Covered Employee or as the child of two Covered Employees, the Maximum Benefit is $1500 per Calendar year under each Employee's Plan.	None except as specified below.	None except as specified below.
5. ALTERNATE/OPTIONAL COURSE OF TREATMENT	This Plan covers the least expensive service or supply which is recognized to be appropriate to treat the dental condition in accordance with broadly accepted standards of practice. Precision attachments, cosmetic treatment, personalization, specialized techniques, implants, experimental procedures, and hospital charges are not covered.	This Plan covers the least expensive service or supply which is recognized to be appropriate to treat the dental condition in accordance with broadly accepted standards of practice. Precision attachments, cosmetic treatment, personalization, specialized techniques, implants, experimental procedures, and hospital charges are not covered.	This Plan covers the least expensive service or supply which is recognized to be appropriate to treat the dental condition in accordance with broadly accepted standards of practice. Precision attachments, cosmetic treatment, personalization, specialized techniques, implants, experimental procedures, and hospital charges are not covered.
6. DIAGNOSTIC SERVICES **a. Oral Exam**	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) limited to 1 visit each 6 months.	No charge.	No charge.
b. X-rays	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) except that bitewing x-rays are limited to once each 12 months and full-mouth x-rays are limited to once each 5 years.	No charge.	No charge, except that full mouth x-rays are limited to once each 24 months.
c. Routine Teeth Cleaning and Periodontal Maintenance Following Periodontal Therapy	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) limited to once each 6 months.	No charge. Limited to once each 6 months.	No charge. Limited to once each 6 months.
d. Fluoride Treatment	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) through age 17 only. Limited to once each 6 months.	No charge.	No charge through age 17. Limit to once each 12 months.
e. Space Maintainers	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) through age 15 only. Limited to once each 6 months.	No charge.	No charge.
f. Sealants (Permanent Molars only)	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) through age 13 only.	No charge through age 13.	No charge through age 13.

	SAN DIEGO CITY SCHOOLS DENTAL BENEFITS PLAN	SAFEGUARD (formerly Health Net Dental	WESTERN DENTAL
7. PERIODONTICS **a. Periodontal Scaling/Root Planing**	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) limited to once each 24 months.	No charge.	No charge.
b. Gingivectomy	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) limited to once each 36 months.	No charge.	No charge.
c. Osseous Surgery	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist).	No charge.	Member pays $55 copay per quadrant.
8. ENDODONTICS **a. Root Canal Therapy**	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist)	No charge.	No charge.
9. RESTORATIVE **a. Fillings and Crowns**	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) for the least expensive service or supply resulting in professionally adequate treatment (as determined by CDN), for fillings and crowns necessary to restore the structure of teeth broken down by decay, injury, abrasion, or attrition except that the charge for replacement of a crown or gold filling is covered only if the crown or filling is over 5 years old and cannot be repaired.	No charge for the least expensive service or supply resulting in professionally adequate treatment for fillings and crowns necessary to restore the structure of teeth broken down by decay or injury, except that member must pay full cost of semi-precious or precious metals.	No charge for the least expensive service or supply resulting in professionally adequate treatment for fillings and crowns necessary to restore the structure of teeth broken down by decay or injury, except that member must pay full cost of semi-precious or precious metals.
10. PROSTHETICS **a. Bridges and Dentures**	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) to replace natural teeth lost while the person is covered under this Plan or to replace an existing prosthesis over 5 years old which cannot be made serviceable.	No charge for the least expensive service or supply resulting in professionally adequate treatment for bridges, dentures, and partial dentures except that member must pay full cost of semiprecious or precious metals.	No charge for the least expensive service or supply resulting in professionally adequate treatment for bridges, dentures, and partial dentures except that member must pay full cost of semiprecious or precious metals
b. Denture Reline (Laboratory)	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist).	No charge. Limited to 2 per year.	No charge. Limited to 2 per year.
11. ORAL SURGERY **a. Extractions**	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist)	No charge.	No charge.
b. General Anesthesia	Plan pays 100% of charges of CDN dentist (70% of CDN Contracted Rate for non-CDN dentist) when necessary for oral surgery as determined by CDN.	No charge for extractions only and only when medically necessary.	No charge for extractions only and only when medically necessary.
12. ORTHONDONTIA **a. Full Banded Cases**	Not covered; however, the Plan will pay $50 per person per lifetime when a CDN orthodontist is used. (This enables members to access CDN's orthodontic network at reduced rates.)	Member is responsible for $1000 copay for up to 24 months active treatment and $250 copay for up to 24 months of retention including the retainer. Additional charges may apply. Refer to Evidence of Coverage booklet for complete details. **Note: For both a. and b. above, the member is responsible for up to $150 maximum copay for beginning and again for ending diagnostic records, including cephalometric x-rays and photographs. Pre-banding devices, appliance, therapy and tooth guidance appliances are NOT a covered benefit. Refer to Evidence of Coverage booklet for complete details.**	Member is responsible for $1000 copay for up to 24 months active treatment and $250 copay for up to 24 months of retention including the retainer. Additional charges may apply. Refer to Evidence of Coverage booklet for complete details. **Note: For both a. and b. above, the member is responsible for up to $150 maximum copay for beginning and again for ending diagnostic records, including cephalometric x-rays and photographs. Pre-banding devices, appliance, therapy and tooth guidance appliances are NOT a covered benefit. Refer to Evidence of Coverage booklet for complete details.**
b. Partially Banded Cases	See 12a above.	Member is responsible for $500 copay for up to 24 months active treatment and $250 copay for up to 24 months of retention including the retainer. Additional Charges may apply. Refer to Evidence of Coverage booklet for complete details.	

	SAN DIEGO CITY SCHOOLS DENTAL BENEFITS PLAN	SAFEGUARD (formerly Health Net Dental	WESTERN DENTAL
13. ORTHODONTIC EXTRACTIONS **a. Per tooth**	Plan pays 100% of CDN dentist charges (70% of CDN Contracted Rate for non-CDN dentist).	Plan pays $75 per tooth limited to $300 lifetime maximum. Requires referral and prior authorization.	No charge at Western Dental Centers only.
b. General Anesthesia	See Item #11b.	Plan pays a lifetime maximum benefit of $100.	Member pays $165 (only at specialist's office)
14. TEMPOROMANDIBULAR JOINT (TMJ) TREATMENT/JAW JOINT TREATMENT	Not covered.	Plan pays a lifetime maximum benefit of $00. Requires referral and prior authorization.	Not covered.
15. ENTAL CARE OUTSIDE OF SERVICE AREA	The plan will pay world-wide benefits.	Emergency treatment provided by a licensed dentist will be reimbursed up to $75 for relief of pain, or conditions that could lead to pain, only.	Emergency services obtained more than 50 miles from the member's selected provider will be reimbursed up to $50 per incident for relief of pain only.
16. CONVERSION	No conversion plan available.	A conversion plan is available upon termination of coverage. Call (800) 999-2848 for information.	A conversion plan is available upon termination of coverage. Call (800) 992-3366 for information.
17. CLAIM FORMS	Claim forms are required.	None. Send documented bill when seeking reimbursement for emergency care.	None. Send documented bill when seeking reimbursement for emergency care.
18. OTHER GROUP INSURANCE	Benefits are coordinated.	Benefits are coordinated.	Benefits are not coordinated.
19. PRE-EXISTING CONDITION	This plan will not provide benefits for any dental treatment which was begun prior to the member's effective date of coverage under this Plan. Also see Items #9a. and #10a.	SafeGuard will not provide benefits for any dental treatment which was begun prior to the member's effective date of coverage under this plan. Also see Item #10a.	Western Dental will not provide benefits for any dental treatment which was begun prior to the member's effective date of coverage under this plan. Also see Item #10a
20. TELEPHONE NUMBERS	Information: (619) 725-8130, option 6 Claims: (760) 233-1900 or (800) 538-5512	Information: (800) 999-2848 Claims: (800) 999-2848	Information: (800) 992-3366 Claims: (800) 992-3366

ENROLLMENT REQUIREMENTS: San Diego Unified School District's play year is January 1 to December 31. Eligible employees must submit the appropriate enrollment forms to the Employee Benefits Office within 31 days of becoming eligible. Once enrolled, you typically cannot make changes until the next open enrollment period, unless you have an IRS-approved "change of family status" (Qualifying Event) during the year, which may include:

- The addition of a dependent through birth, adoption or marriage
- The loss of a dependent through divorce or death, or if your child reaches the maximum age limit for coverage
- A change in your or your spouse's employment status including loss of employment or a change from full-time to part-time, or vice versa
- A substantial change in your employer's benefits coverage or a spouse's coverage
- A relocation that impacts network coverage

You must adjust your benefit election within 31 days of the Qualifying Event. You will be required to certify your change in family status. If you experience a Qualifying Event, please contact the Employee Benefits Office for assistance.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern. For further information on the above plans contact the Employee Benefits Office at (619)725-8130, option 6.

Selecting a dental plan is an important and personal matter. Among the many factors which need to be considered are cost, level of coverage, convenience, service area, quality and number of dentist, and type of plan. There is no assurance, however, that a particular dentist will continue to participate in a specific plan. It is the patient's responsibility to verify that a particular dentist is a participant in a plan prior to obtaining services or supplies.