

Exhibit A.2 Pediatric Oral and Vision Care

Table E2.1. Pediatric Oral and Vision Coverage included in EHB Benchmark Plans

	Aetna HMO	Anthem BCBS HMO	ConnectiCare HMO	Anthem BCBS State Preferred HMO
Dental Care:				
Dental Check-Up for Children	N	N	N	N
Vision Care:				
Vision Screening for Children	Y	Y 1 exam/2 years	Y 1 exam/year	Y 1 exam/year
Eye Glasses for Children	N	Y* lenses: \$20 copay frame: \$120/2 years OR; contacts: \$105/year <i>*May be considered a Rider by CCIIO</i>	N	N

Table E2.2. Potential EHB Supplemental Coverage: Example FEDVIP Vision Plan (BCBS Vision Care)

	Standard Option (Coverage and Member Payment)	High Option (Coverage and Member Payment)
Diagnostic:		
Eye exam, includes dilation if professionally indicated	1 exam/year In-Network: Nothing Out-of-Network: All charges	1 exam/year In-Network: Nothing Out-of-Network: Expenses in excess of \$30
Eyewear: <i>Member may choose prescription glasses or contacts lenses</i>		
Lenses Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters. Note: All lenses include scratch resistant coating with no additional copayment.	1 pair/year In-Network: Nothing Out-of-Network: All charges	1 pair/year In-Network: Nothing Out-of-Network: Expenses in excess of fee schedule allowance: \$25 single vision \$35 lined bifocal \$45 lined trifocal \$45 lenticular
Frames	1 frame/2 years In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a \$130 allowance. Additionally, a 20% discount applies to any amount over \$130* Out-of-Network: All charges	1 frame/year In-Network: Collection Frame: Nothing Non-Collection Frame: Expenses in excess of a \$150 allowance. Additionally, a 20% discount applies to any amount over \$150* Out-of-Network: Expenses in excess of \$30
Optional Lenses and Treatments	Covered In-Network Only	Covered In-Network Only
Contact Lenses	1 fitting & set of lenses/year In-Network: Expenses in excess of a \$130 (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over \$130. Expenses in excess of \$600 for medically necessary contact lenses. Out-of-Network: All charges	1 fitting & set of lenses/year In-Network: Expenses in excess of a \$150 (may be applied toward the cost of evaluation, materials, fitting and follow-up care). Additionally, a 15% discount applies to any amount over \$150. Expenses in excess of \$600 for medically necessary contact lenses. Out-of-Network: Expenses in excess of fee schedule allowance of: \$75 elective contact lenses; \$225 medically necessary contact lenses.

Table E2.3. Comparison of Potential EHB Supplemental Coverage Options for Pediatric Oral Care

	CHIP (Husky B) Dental Benefits	FEDVIP Dental Benefits: Aetna Dental
Preventive and Diagnostic Services	Dental preventive and diagnostic services include: <ul style="list-style-type: none"> • Exams, 1 every 6 months • X-rays: Bitewings, 1 time/year; other X-rays, as needed • Sealants: on premolar and molar teeth • Fluoride Treatments <ul style="list-style-type: none"> - Including, topical therapeutic fluoride varnish application for clients with moderate to high risk of dental decay • Access for Baby Care Early Dental Examination and Fluoride Varnish where an oral health screen, oral health education and fluoride varnish are applied to children’s teeth during well child examinations up to 4 years of age 	Dental preventive and diagnostic services include: <ul style="list-style-type: none"> • Exams, two per year • X-rays: Bitewings, 1 time/year (but vertical bitewings, 1 set/3 years); other X-rays, as needed • prophylaxis, 2 times/year • fluoride treatments: <ul style="list-style-type: none"> - 2 treatment/year - topical therapeutic fluoride varnish application for clients with moderate to high risk of dental decay • sealants: on permanent molars under age 19; one sealant/tooth/3 years • space maintainers, fixed or removable, under age 19
Dental Orthodontia (under age of 19)	√ max. \$725 allowance	√ max. \$1,500 allowance
Replacement Retainer	Limited to one time per lifetime	not covered
Amalgam and Composite Restorations (Fillings)	√	√
Fixed Prosthodontics: Crowns, Inlays and Onlays	√	√
Recent Bridges, Crowns Inlays & Space Maintainers	√	√ limited to once per 6 months/tooth
Removable Prosthodontics: Full or Partial Dentures	√	√
Repair, Relining and Rebasing Dentures	√	√ not covered in first 6 months; limited to once/3 years
Intermediate Endodontic Services	√	√ pulp cap; partial pulpotomy for apexogenesis; pulpal therapy
Major Endodontic Services: Root Canal Treatment, Retreatment of root canal therapy; apicoectomy; apexification	√	√
Oral Surgery: Surgical Extraction, including impacted teeth	√	√
Non-surgical Extraction	√	√
Periodontal Surgery and Services	√	√ periodontal scaling limited to once per quadrant/2 years; maintenance limited to twice/year
Space Maintainers	√	√
General Anesthesia and Sedation	√	√
Miscellaneous Adjunctive Procedures	√	√ no insured if covered by other medical insurance
Miscellaneous Services	<i>unsure</i>	√ fabrication of occlusal guard and athletic mouthguard; internal bleaching