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# **Pediatric Oral and Vision Care Essential Health Benefits under the Affordable Care Act**

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A review of options for California

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Joel Diringer, JD, MPH

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*Supported by the California HealthCare Foundation,  
based in Oakland, California*

## Table of Contents

INTRODUCTION .....	I
FEDERAL GUIDANCE.....	I
1. Essential Health Benefits (EHB) Bulletin.....	I
Pediatric Oral and Vision Services.....	2
Cost sharing and actuarial value .....	3
2. Frequently Asked Questions on Essential Health Benefits Bulletin .....	3
3. Federal regulations.....	3
4. Additional guidance.....	4
CALIFORNIA ACTIVITIES.....	4
STAKEHOLDER INPUT .....	4
ANALYSIS AND RECOMMENDATIONS: .....	5
Pediatric oral care .....	5
Non-orthodontia differences .....	6
Orthodontia.....	6
Stakeholder input.....	7
Additional considerations .....	8
Proposed elimination of Healthy Families .....	8
Vision Care .....	8
CONCLUSION.....	9
APPENDIX A – COMPARISON OF PEDIATRIC ORAL CARE.....	A-I
APPENDIX B – COMPARISON OF PEDIATRIC VISION BENEFITS .....	B-I

*Diringer and Associates is a California-based health policy consulting firm specializing in research, program development and evaluation. Since 2001, Diringer and Associates has provided nonprofit, governmental and philanthropy clients with solutions crafted to meet the unique challenges of their health care issues focusing on health coverage and oral health.*

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## INTRODUCTION

Diringer and Associates was retained by the California HealthCare Foundation (CHCF) to provide expert analysis and recommendations to legislative staff regarding the Affordable Care Act's Essential Health Benefits for pediatric oral and vision services.

Specifically, we were requested to:

- research the federal guidance on selecting appropriate Essential Health Benefits for pediatric oral and vision services;
- conduct an analysis of possible benchmark plans for pediatric dental and vision coverage and develop a table comparing the scope of benefits and limitations of coverage;
- review stakeholder comments and conduct a interviews to elicit further input;
- develop a briefing paper for CHCF and legislative staff with recommendations.

This report summarizes the research including the federal directives, comparison of the plans and stakeholder input. Based on the research, we make recommendations for the essential health benefits for pediatric oral and vision care. Two charts comparing the dental and vision plans' benefits and limitations are contained in the Appendices.

## FEDERAL GUIDANCE

### I. [Essential Health Benefits \(EHB\) Bulletin](#)

On December 16, 2011, the Department of Health and Human Services (HHS) Center for Consumer Information and Insurance Oversight issued an Essential Health Benefits Bulletin to provide information and solicit comments on the regulatory approach that HHS plans to propose to define essential health benefits (EHB) under section 1302 of the Affordable Care Act (ACA).

Relevant portions of the Bulletin are as follows:

Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014. Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories:

- (1) ambulatory patient services,
- (2) emergency services
- (3) hospitalization,
- (4) maternity and newborn care,
- (5) mental health and substance use disorder services, including behavioral health treatment,
- (6) prescription drugs,

- (7) rehabilitative and habilitative services and devices,
- (8) laboratory services,
- (9) preventive and wellness services and chronic disease management, and
- (10) pediatric services, including oral and vision care.

Section 1302(b)(2) of the ACA instructs the Secretary that the scope of EHB shall equal the scope of benefits provided under a “typical employer plan.” HHS intends to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a “typical employer plan” in that State.

The HHS analysis suggested that four benchmark plan types for 2014 and 2015 best reflect the statutory standards for EHB:

- (1) the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
- (2) any of the largest three State employee health benefit plans by enrollment;
- (3) any of the largest three national FEHBP plan options by enrollment; or
- (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are “substantially equal” to the benefits of the benchmark plan selected by the State and modified as necessary to reflect the 10 coverage categories.

One of the challenges with the described benchmark plan approach to defining EHB is meeting both the test of a “typical employer plan” and ensuring coverage of all 10 categories of services. Not every benchmark plan includes coverage of all 10 categories of benefits identified in the Act. For example, many of the benchmark plans do not routinely cover pediatric oral or vision services.

### **Pediatric Oral and Vision Services**

For pediatric oral care, HHS is considering two options for supplementing benchmarks that do not include these categories. The State may select supplemental benefits from either:

- 1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
- 2) The State’s separate CHIP program.

HHS noted that if a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards. Furthermore, HHS intends to propose the EHB definition would not include non-medically necessary orthodontic benefits.

For pediatric vision care, HHS intends to propose the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment. The rationale for a different treatment of this category is that CHIP does not require vision services.

### **Cost sharing and actuarial value**

In determining Essential Health Benefits, only the covered services are considered, not the cost sharing such as deductibles, copayments and dollar limitations. A separate guidance addresses the determination of actuarial value. However, amount, duration and scope limitations are considered in determining the EHB.

## **2. Frequently Asked Questions on Essential Health Benefits Bulletin**

Additional guidance was provided on February 17, 2012 when CMS issued the document, Frequently Asked Questions on Essential Health Benefits Bulletin. In sections relevant to pediatric oral and vision services, CMS stated:

“5. How must a State supplement a benchmark plan if it is missing coverage in one or more of the ten statutory categories?

A: We intend to propose that if a benchmark plan is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category, as described in the Bulletin.

...

“Our research found that three categories of benefits - pediatric oral services, pediatric vision services, and habilitative services - are not included in many health insurance plans. Thus, the Bulletin describes special rules to ensure meaningful benefits in those categories:

...

“For pediatric oral care, we are considering proposing that the State would supplement the benchmark plan with benefits from either:

- o The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
- o The State’s separate Children’s Health Insurance Program (CHIP).

“For pediatric vision care, we are considering proposing that the State would supplement the benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment.”

## **3. Federal regulations**

On March 27, 2012, HHS issued final regulations related to Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. Among many other provisions, the rules set standards for dental plans that are allowed to offer pediatric

coverage in the Exchange. While not directly affecting the EHB definitions, §155.1065 of the regulations<sup>1</sup>

- allows dental plans to be offered as a stand-alone dental plan, or in conjunction with a qualified health plan;
- applies the same cost-sharing limits and restrictions on annual and lifetime limits to stand-alone dental plans as are applied to qualified health plans;
- requires stand-alone dental plans to offer child-only plans in the Exchanges;
- requires the Exchange to ensure that participating dental plans have the provider network capacity to offer sufficient access to all eligible children;
- requires that stand-alone dental plans comply with all certification standards for qualified health plans except for those related to services other than pediatric oral health care; and
- directs the Exchanges to collect rate information on pediatric dental benefits for the purposes of determining advance payments of the premium tax credit.

#### 4. Additional guidance

On July 3, 2012, CMS released a list of the FEDVIP oral and vision plans with the highest enrollment that could be used as benchmark plans.<sup>2</sup> For California, the dental plan with the highest enrollment is the MetLife Federal Dental Plan – High; for vision care the benchmark plan is FEP BlueVision – High.

No further guidances or regulations have been issued regarding the scope of services to be provided under the pediatric oral or vision services provisions.

## CALIFORNIA ACTIVITIES

AB 1453, as amended on April 17, 2012, and SB 951, as amended on April 16, 2012, propose the “Kaiser Small Group HMO” plan as the EHB benchmark in California. For pediatric oral care and vision care, the legislation proposes that the benefits be those in the FEDVIP dental plan and vision plan with the largest national enrollment as of the first quarter of 2012. The bill further states that the scope and duration limits imposed on the services and benefits described shall be no greater than those in the benchmark FEDVIP dental plan and vision plan.

## STAKEHOLDER INPUT

In preparing this report, written and electronic comments and correspondence was reviewed from Delta Dental, California Association of Dental Plans (CADP), National Health Law Program (NHeLP), California Dental Association (CDA), California Society of Pediatric Dentistry (CSPD), Children Now (individually and on behalf of the children’s

<sup>1</sup> <http://www.regulations.gov/#!documentDetail;D=HHS-OS-2011-0020-2420>

<sup>2</sup> <http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf.pdf>

health coverage coalition), National Health Law Program (NHeLP) and California Optometric Association (COA).

In addition, interviews were conducted with the following stakeholders:

Children’s Dental Health Project – Colin Reusch and Catherine Dunham (DC)  
Children Now – Eileen Espejo and Michael Odeh (Oakland)  
NHeLP – Michelle Lilienfeld (LA)  
University of Pacific – Dr. Paul Glassman (SF)  
UCLA – Dr. Francisco Ramos-Gomez (LA)  
MRMIB – Ellen Badley (Sacramento)  
Delta Dental of California – Jeff Album, Dr. John Yamamoto (SF)  
Denti-Cal – Dr. Robert Isman (Sacramento)  
California Dental Association – Allison Barnett (Sacramento)  
California Society of Pediatric Dentistry -- Dr. Paul Reggiardo (Sacramento)  
California Optometric Association – Kristine Schultz (Sacramento)  
American Optometric Association – Brian Reuwer (DC)  
Kaiser Health Plan – David Link (email)

Additional information was obtained as a result of the interviews including clarification of benefits, data on orthodontic utilization in Medi-Cal, and best practices in children’s dental care.

## ANALYSIS AND RECOMMENDATIONS:

### Pediatric oral care

The benchmark plan selected by the legislation, the Kaiser Small Group HMO, has very limited dental coverage. It covers dental services only if they are an integral part of covered reconstructive surgery for cleft palate. The plan also pays for dental anesthesia for procedures performed at Kaiser facilities, but does not cover the actual dental services.

If benchmark plans do not provide pediatric dental coverage, the December 2011 federal guidance provides for supplementing benchmark plans with benefits from either of 1) the FEDVIP dental plan with the largest enrollment or 2) the separate CHIP program. If a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards.

The current CHIP (Healthy Families) dental benefits are codified at: 10 CCR §§2699.6709 and 6713. The largest FEDVIP plan is the MetLife plan (<http://www.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf>).

### Non-orthodontia differences

There are some minor differences between the plans, with the major difference being the coverage of orthodontia. A table comparing the Kaiser, MetLife and Healthy Families benefits and limitations is contained in Appendix A.

Among the non-orthodontia differences are that MetLife does not offer some benefits that are provided under Healthy Families: oral hygiene instruction, biopsy of oral tissue, vital pulpotomy and pulp vitality testing, oral sedation, nitrous oxide and local anesthesia.

While oral hygiene instruction is not generally covered by dental plans, some of these benefits such as biopsy of oral tissue, pulp vitality testing and oral sedation, are reported to be important to pediatric dental care and should be covered. It has also been asserted that MetLife does not cover “accidental injury.” However, there is nothing in the plan’s explanation of benefits that would indicate that it is not covered.

While the MetLife plan has significant copays and coverage limits these limits should not be used when determining EHB. These cost sharing provisions affect the actuarial value of a plan, but do not affect the scope of benefits. However, non-dollar limits, such as limiting services within a time period are allowed. Under the Bulletin plans may be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

### Orthodontia

The December Bulletin states that HHS will propose that EHB would not include non-medically necessary orthodontia services (Page 11), i.e. only medically necessary orthodontia is considered an EHB.

MetLife offers a richer orthodontia benefit, albeit with a 24 month waiting period before coverage begins. Orthodontia services are covered up to age 19, with a maximum lifetime maximum of \$1500 in network (\$1000 out of network) for the standard option and \$3500 for the high option. There is also a 50% copay. There is no “medical necessity” standard for MetLife’s orthodontia coverage, but the plan does not pay for purely cosmetic services.

Orthodontia is carved out of the Healthy Families dental plan, and coverage is provided through California Children’s Services (CCS) for a limited scope of medically necessary orthodontia (10 CCR §2699.6709 (a) (8)). The criteria that CCS uses are identical to those that have been used by the Denti-Cal program since the 1990’s. Children may obtain orthodontia as 1) the result of certain qualifying conditions, 2) a score of 26 or higher on the Handicapping Labio-Lingual Deviation (HLD) Index, or 3) under Early and Periodic Screening, Diagnosis, and Treatment – Supplemental Services (EPSDT-SS) criteria. The criteria and treatment authorization processes are spelled out in the Medi-

Cal Dental Program Provider Handbook beginning at page 9-3. (<http://www.denti-cal.ca.gov/WSI/Publications.jsp?fname=ProvManual>).

To provide some context on utilization and cost of orthodontia services, data were obtained from Denti-Cal. In Fiscal Year 2010-11, approximately 30,000 children ages 0-20 received orthodontic services out of nearly 6 million Medi-Cal eligibles (.5%) and 1.6 million Medi-Cal users (1.8%) for that age group. Approximately \$22 million was spent on orthodontia services or 4.8% of the amount spent by Denti-Cal on this population. Similar data were not obtained from CCS. The Denti-Cal utilization or cost data may not be reflective of costs and utilization in a new plan that covers higher income children whose parents are paying premiums.

### Stakeholder input

The dental practice and coverage stakeholders (CDA, CSPD, Delta and CADP) specifically recommended adopting the Healthy Families plan as the benchmark. Reasons for favoring the Healthy Families plan are that it is designed as a pediatric package of benefits, it is familiar to California providers and subscribers, and it contains some additional coverages from the MetLife plan.

The children's advocates (Children Now coalition) did not take a position on which plan should be the benchmark, but emphasized that medically necessary orthodontia must be included. NHeLP supported the legislative language for the MetLife plan with the additional provision that there not be a 24 month waiting period for orthodontia services. NHeLP indicated that if the legislation were amended, they would review the alternative plan.

On balance, it appears that Healthy Families provides somewhat greater pediatric benefits than the MetLife plan and it a specific set of pediatric benefits familiar in California. The differences lie in orthodontia. Although Healthy Families carves out orthodontia, the benefits provided to children enrolled in Healthy Families are easily defined by reference to the CCS and Denti-Cal standards. These standards are for "medically necessary" orthodontia only, in conformance with the EHB definition proposed in the Bulletin.

Our recommendation is to use the Healthy Families benefits currently in existence, explicitly adding the orthodontia criteria used by CCS and Denti-Cal which is through a point system using the Handicapping Labio-Lingual Deviation (HLD) index, an automatic qualifying condition, or under the Early Periodic Screening, Diagnostic, and Treatment - Supplemental Services (EPSDT-SS) criteria when there are extenuating medical circumstances.. The legislation could either 1) add the specific language of the criteria in the legislation or 2) reference the criteria in the Denti-Cal Handbook.

### Additional considerations

There were additional comments related to essential health benefits that would expand the scope of either benchmark plan. There was a recommendation that plans be required to reimburse a covered service, regardless of the place of delivery of the service. This relates to telehealth, where a dentist may review an x-ray remotely after it was taken in a community setting and develop a treatment plan with offsite members of the dental team. Healthy Families does not currently reimburse services provided through telehealth. The MetLife plan is silent on whether it covers telehealth, and it specifically excludes “telephone consultations.”

An additional recommendation was for developing a bundled package of benefits for young children ages 0-3 which would provide for risk assessment, intensive intervention for high risk children with disease management based on the risk. Under this modality, some children would be seen more often than currently allowed, while others might not be seen as frequently. This would incorporate Caries Management By Risk Assessment (CAMBRA) as supported by the CDA and promoted by Dr. Francisco Ramos-Gomez at UCLA.

A related recommendation was to require diagnostic dental codes. Currently, dentists provide treatment codes, but do not provide any indication of diagnoses. With diagnosis codes it becomes possible to measure quality and appropriateness of care, as well as determine whether actual oral health outcomes are improving.

### Proposed elimination of Healthy Families

Under the state budget agreement Healthy Families is to be phased out and eliminated by the end September 2013. The choices for a benchmark plan identified in the Bulletin are either the FEDVIP plan or the plan in a separate CHIP program. However, the Bulletin further states in a footnote that “If a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards.” Thus, California would appear to be able to use the Healthy Families plan as a benchmark, even if it does not continue to exist. It could do that by 1) identifying the current Healthy Families plan as the benchmark plan (with the additional orthodontia language), 2) referencing the current regulations (10 CCR sections 2699.6709 and 6713), or 3) by specifying the specific benefits.

### Vision Care

The federal EHB bulletin provides that when the selected benchmark plan does not cover pediatric vision services that the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment (Page 11). The Bulletin does not provide for using the CHIP plan for supplemental benefits.

There is no specific federal guidance on what comprises pediatric vision services, although stakeholders argue that by specifically adding pediatric vision services that Congress intended that vision care services go beyond preventive services and include eyeglasses or lenses. A table comparing the Kaiser and three FEDVIP vision plan benefits and limitations is contained in Appendix B. The largest FEDVIP plan is FEP Blue Vision – High (<http://www.opm.gov/insure/health/planinfo/2012/brochures/FEPBlueVi.pdf>)

The Kaiser Small Group plan contains limited vision benefits as one of its preventive care services under health reform (page 24 of the Small Business Evidence of Coverage). The vision care is limited to a vision screen and eye exam for refraction. The plan does not cover eyeglasses. Medically necessary contact lenses are covered to treat aniridia (missing iris), and to treat aphakia (absence of the crystalline lens of the eye) for members through age 9.

There are three FEDVIP vision plans, with Blue Vision being the largest. Blue Vision provides for annual exams, annual frames and lenses, and an allowance for contact lenses. There are various co-pays for lens upgrades. Blue Vision also has coverage for low vision services. The VSP plan is similar, but does not have coverage for “low vision care”.

The advocates support supplementing the Kaiser vision screening benefit with the services in the FEDVIP plan. We concur with that recommendation. According to the Bulletin, if the benchmark plan does not cover pediatric vision services, the State no option but to use the FEDVIP plan with the largest enrollment – FEP Blue Vision - High.

## CONCLUSION

Upon reviewing the federal guidance, developing a comparison of the alternative plans, and seeking input of stakeholders and experts, it is our recommendation that the benchmark for the pediatric dental benefits be the current Healthy Families benefits, provided that the scope of orthodontic benefits be specifically delineated. For vision benefits, it is recommended that the benchmark Kaiser plan be supplemented with benefits in the FEDVIP plan with the largest enrollment FEP Blue Vision - High.

The Legislature can consider additional benefits such as coverage for telehealth services and for a robust pediatric package that would include intensive preventive and treatment services for very young child based on their assessed risk.

## APPENDIX A – COMPARISON OF PEDIATRIC ORAL CARE

Benefit	Kaiser Small Group HMO	CA CHIP – Healthy Families		FEDVIP- MetLife	
	<b>Covered services</b>	<b>Covered services</b>	<b>Coverage limits</b>	<b>Covered services</b>	<b>Coverage limits</b>
Source:	<a href="http://www.healthexchange.ca.gov/FederalGuidance/Pages/Default.aspx">http://www.healthexchange.ca.gov/FederalGuidance/Pages/Default.aspx</a>	California Code of Regulations 10 CA ADC §§ 2699.6709, 6713		<a href="http://www.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf">http://www.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf</a>	
Deductibles and caps	<p>Most consultations, exams, and treatment: \$30 per visit</p> <p>Hospital inpatient care: \$400 per day</p> <p>Outpatient surgery: \$200 per procedure</p> <p>Deductible for certain drugs: \$250 per calendar year</p>		No copays for most services. No annual cap or deductible.		<p>No annual deductible in-network; Out-of-network calendar year deductible of \$100 per person for standard option; \$50 for high option.</p> <p>Annual non-orthodontic benefit caps: Standard option: \$1200 in network; \$600 out-of-network; High option: \$10,000.</p> <p>Orthodontic lifetime maximum: Standard option: \$1500 in network; \$1000 out of network; High option: \$3500 24 month waiting period</p>

Benefit	Kaiser Small Group HMO	CA CHIP – Healthy Families		FEDVIP- MetLife	
	Covered services	Covered services	Coverage limits	Covered services	Coverage limits
Diagnostic Services	None	Oral exams, X rays, specialist consultations	Oral exams – twice a year Bitewing X rays – once a year; Full mouth and panoramic X rays – once in 3 year period; No copay	Oral exams, X rays, specialist consultations	Exams must be six months apart; Bitewing X rays – every 6 months; Full mouth and panoramic X rays – once every 5 years;  Copays: Standard option: none in network; 40% out of network; High option: none in network; 10% out of network.
Preventive Care	None	Fluoride, oral hygiene instruction, cleanings (prophylaxis), sealants, space maintainers	Not to exceed two in a 12 month period; 3 <sup>rd</sup> cleaning provided for high risk patients; No copay	Prophylaxis, fluoride, sealant, space maintainers  No oral hygiene instruction	Fluoride – 2 every 12 months; Sealants – every 3 years per tooth;  Copays: same as Diagnostic
Restorative Dentistry (Fillings)	None	Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries	No copay	Amalgam, resin-based composite	Copays: Standard option: 45% in network; 60% out of network;  High option: 30% network allowance in network; 40% out of network.

Benefit	Kaiser Small Group HMO	CA CHIP – Healthy Families		FEDVIP- MetLife	
	<b>Covered services</b>	<b>Covered services</b>	<b>Coverage limits</b>	<b>Covered services</b>	<b>Coverage limits</b>
Oral Surgery	Coverage for dental anesthesia at Kaiser facility for limited patients only; no coverage for dentist;	Extractions, including surgical extractions Removal of impacted teeth Biopsy of oral tissues Alveolectomies Excision of cysts and neoplasms Treatment of palatal torus Treatment of mandibular torus (bony growth) Frenectomy (tissue removal) Incision and drainage of abscesses, Post-operative services, Root recovery (separate procedure).	Copayment of \$5/\$10 copayment for the removal of impacted teeth for a bony impaction, and per root recovery  Copay depends on income category	Extractions, including surgical extractions, Removal of impacted teeth, Alveolectomies, Excision of cysts Incision and drainage of abscesses  Not specifically covered: Excision of neoplasms Treatment of palatal torus (bony growth) Treatment of mandibular torus Frenectomy (tissue removal) Post-operative services Root recovery (separate procedure) Biopsy of oral tissues	Same copays as Restorative
Endodontic		Direct pulp capping Pulpotomy and vital pulpotomy Apexification filling with calcium hydroxide Root amputation Root canal therapy including culture canal Re-treatment of previous root canal therapy Apicoectomy Vitality tests.	Copayment of \$5/10 copayment per canal for root canal therapy or retreatment of previous root canal therapy and per root for an apicoectomy  Copay depends on income category	Direct pulp capping, Pulpotomy Root canal therapy, Apicoectomy Apexification Root amputation Re-treatment of previous root canal therapy  Not specifically covered: Vital pulpotomy Vitality tests	Limits on pulpal therapy to once per tooth per lifetime;  Same copays as Restorative for Intermediate benefit; Same copays as Removable Prosthetics for Major Services

Benefit	Kaiser Small Group HMO	CA CHIP – Healthy Families		FEDVIP- MetLife	
	Covered services	Covered services	Coverage limits	Covered services	Coverage limits
Periodontics		Emergency treatment, including treatment for periodontal abscess and acute periodontitis Periodontal scaling and root planing Subgingival curettage Gingivectomy Osseous or muco-gingival surgery.	Periodontal scaling and root planing, and subgingival curettage, limited to 5 quadrant treatments in any 12 consecutive months  \$5/10 copayment per quadrant for osseous or muco-gingival surgery  Copay depends on income category	Emergency treatment, including treatment for periodontal abscess Periodontal scaling and root planing Gingivectomy Osseous or muco-gingival surgery  Not specifically covered: Subgingival curettage	One every 24 months; Gingivectomy limited to 1 every 36 months  Same copays as Restorative for Intermediate services; Same copays as Removable Prosthetics for Major Services

Benefit	Kaiser Small Group HMO	CA CHIP – Healthy Families		FEDVIP- MetLife	
	Covered services	Covered services	Coverage limits	Covered services	Coverage limits
Crown and Fixed Bridge		<p>Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel,  Related dowel pins and pin build-up  Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold  Recementation of crowns, bridges, inlays and onlays  Cast post and core, including cast retention under crowns  Repair or replacement of crowns, abutments or pontics.</p>	<p>Up to five units of crown or bridgework per arch.  Replacement of each unit is limited to once every five years.  Tissue conditioning, limited to two per denture  \$5 copayment for porcelain crowns, porcelain fused to metal crowns, full metal crowns, and gold onlays or 3/4 crowns; per pontic.  Copoly depends on income category  The copayment for any precious (noble) metals used in any crown or bridge is the full cost of the actual precious metal used</p>	<p>Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel  Related dowel pins and pin build-up.  Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold,  Recementation of crowns, bridges, inlays and onlays  Not specifically covered:  Cast post and core, including cast retention under crowns</p>	<p>Crowns limited to every 60 months  Same copays as Removable Prosthetics</p>

Benefit	Kaiser Small Group HMO	CA CHIP – Healthy Families		FEDVIP- MetLife	
	Covered services	Covered services	Coverage limits	Covered services	Coverage limits
Removable Prosthetics		Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers Office or laboratory relines or rebases Denture repair and adjustment Tissue conditioning Denture duplication Stayplates.	\$5/\$10 copayment for a complete maxillary or mandibular denture; partial acrylic upper or lower denture with clasps; partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles; removable unilateral partial denture; reline of upper, lower or partial denture when performed by a Laboratory; denture duplication.  Dentures are not to be replaced within 5 years unless certain conditions are met.  Office or laboratory relines or rebases, limited to one per arch in any 12 consecutive months.  Copay depends on income category	Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, Office or laboratory relines or rebases,  Repair, reline and rebase dentures  Not specifically covered: Stayplates	Copays: Standard option: 65% in network; 80% out of network;  High option: 50% network allowance in network; 60% out of network  Prosthodontics limited to every 60 months;  Rebase or reline limited to 1 in 36 month period beginning 6 months after initial installation;

Benefit	Kaiser Small Group HMO	CA CHIP – Healthy Families		FEDVIP- MetLife	
	Covered services	Covered services	Coverage limits	Covered services	Coverage limits
Other Benefits		Local anesthetics Oral sedatives Nitrous oxide Emergency treatment Palliative treatment	No copay	Palliative treatment General anesthesia IV conscious sedation  Not covered: Local anesthesia Oral sedatives, Nitrous oxide	Copays: Standard option: 45% in network; 60% out of network;  High option: 30% network allowance in network; 40% out of network.
Orthodontia Services	Covered if an integral part of covered reconstructive surgery for cleft palate. \$400 copay each inpatient procedure; \$200 copay for each outpatient procedure; \$30 copay per consultation;	Not a Healthy Families Program covered benefit.  Services are provided to members under the age of 19 through the California Children’s Services Program (CCS) when condition meets the CCS program criteria.	[check CCS copays]		Under 19 years of age;  24 month waiting period;  Lifetime maximums: Standard: \$1500 in network; \$1000 out of network; High option: \$3500  Copays: Standard option: 50% in network; 50% out of network;  High option: 50% in network; 50% out of network.
Implants		None		Implant is a covered procedure of the plan only if determined to be a dental necessity.	1 every 60 months

## APPENDIX B – COMPARISON OF PEDIATRIC VISION BENEFITS

Benefit	Kaiser Small Group HMO	FEDVIP- VSP High Option	FEDVIP – VSP Basic option	FEDVIP – FEP BlueVision	United HealthCare Vision
Source	<a href="http://www.healthexchange.ca.gov/FederalGuidance/Pages/Default.aspx">http://www.healthexchange.ca.gov/FederalGuidance/Pages/Default.aspx</a>	<a href="http://federal.vsp.com/html/fed-plan1.jsp">http://federal.vsp.com/html/fed-plan1.jsp</a>	<a href="http://federal.vsp.com/html/fed-plan1.jsp">http://federal.vsp.com/html/fed-plan1.jsp</a>	<a href="http://www.opm.gov/insure/health/planinfo/2012/brochures/FEPBlueVi.pdf">http://www.opm.gov/insure/health/planinfo/2012/brochures/FEPBlueVi.pdf</a>	<a href="https://www.myuhcvision.com/members/fedvip_index.jsp">https://www.myuhcvision.com/members/fedvip_index.jsp</a>
Comprehensive vision exam	Covered as preventive service	Well vision exam every calendar year \$10 copay	\$10 copay	No cost in network every calendar year	Every 12 months \$10 copay
Lenses	None	\$150 allowance for frames and lenses. Once a calendar year \$10 copay for: Anti-reflective coating Scratch-resistant coating Polycarbonate lenses Tints/photochromic lenses—Transitions® UV protection Additional copay for: Standard progressive lenses Premium progressive lenses Custom progressive lenses	\$120 allowance for frames and lenses \$20 copay Scratch-resistant coating Polycarbonate lenses  Additional copay for: Standard progressive lenses Premium progressive lenses Custom progressive lenses	One pair per calendar year; Polycarbonate lenses covered for children. Additional copays for: progressive, photochromic, polarized and other special lenses.	Every 12 months Scratch resistant and polycarbonate; High Plan: adds basic progressive (extra copay) and tinted lenses, UV coating  Copay \$25 for material on standard plan; \$10 on high plan.

Benefit	Kaiser Small Group HMO	FEDVIP- VSP High Option	FEDVIP – VSP Basic option	FEDVIP – FEP BlueVision	United HealthCare Vision
Frames		\$150 allowance for frames; lenses. Once a calendar year \$10 copay for glasses	\$120 allowance for frames; lenses \$20 copay	<u>High Option</u> : covered once every calendar year. No charge for standard “collection” or \$150 credit. <u>Standard Option</u> : covered once every other calendar year. No charge for standard “collection” or \$130 credit	\$50 wholesale frame allowance (\$120-150 retail) at provider; \$130 allowance at retail chains
Contact lenses	Up to 2 Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris):  Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9:	\$150 allowance for contacts every calendar year	\$120 allowance for contacts every calendar year	High option: \$130 allowance for contacts every calendar year; \$600 allowance if medically necessary with prior auth. Standard option: \$150 allowance for contacts every calendar year; \$600 allowance if medically necessary with prior auth. Medically necessary includes: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.	Covered in full or \$125 allowance if out of network.

Benefit	Kaiser Small Group HMO	FEDVIP- VSP High Option	FEDVIP – VSP Basic option	FEDVIP – FEP BlueVision	United HealthCare Vision
Low vision care	None	Not specifically covered	Not specifically covered	Pre-authorized low vision services include one comprehensive low vision evaluation every 5 years, with a maximum charge of \$300; maximum low vision aid allowance of \$600 with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of \$100 each visit.	
Exclusions				Medical treatment of eye disease or injury; <ul style="list-style-type: none"> <li>• Visual therapy;</li> </ul> Replacement of lost/stolen eyewear; Non-prescription (Plano) lenses; <ul style="list-style-type: none"> <li>• Two pairs of eyeglasses in lieu of bifocals;</li> </ul> Services or materials provided as a result of intentionally self-inflicted injury or illness; plus others.	