LA HAP Bulletin

June 21st, 2017

Clarifications on LA HAP coverage of dental and vision services *(updated 7-25-17)*

This Bulletin seeks to clarify LA HAP's scope of coverage regarding dental and vision services. Please contact Alicia at 504-568-5489 *(please note the new number)* if you have any questions.

Dental insurance: Unlike health insurance, the dental insurance industry is not subject to the same standards as the medical insurance industry under the Patient Protection and Affordable Care Act. Dental coverage is typically more limited than medical coverage. At the same time, dental care services are consistently cited by our clients as being among their most urgent needs. Fortunately, HRSA has also recognized this need and has worked with state ADAPs to find the best ways that ADAPs such as LA HAP can help support dental care.

LA HAP accordingly covers the following additional services associated with dental plans, provided the service itself is on the insurer's Schedule of Benefits:

- Services provided before a client has moved through the initial waiting period for services imposed by their insurer
    - Example: the insurance company says members must pay premiums for 6 months before most services can be covered. LA HAP can cover costs incurred during this waiting period.
- Services provided after a client has reached their annual benefit maximum
    - Example: the insurer has paid $2,000 on a client's behalf throughout the year and will pay no more. LA HAP can cover costs incurred above this maximum until the plan year resets.
- Services provided above the maximum annual number set by the insurer
    - Example: the insurer allows one crown replacement per year. LA HAP can cover additional necessary replacements at full cost until the plan year resets.
- Charges billed back to a client because the provider's charge exceeded the amount allowed by the insurer (balance billing)
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    - Example: an insurer pays $40 on a provider's $100 claim. LA HAP can cover the remaining $60 if this amount is balance billed to the client.

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LA HAP is part of the Office of Public Health's STD/HIV Program
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- Services provided by an out-of-network provider when no in-network provider was available

In all instances described above:

- **The service must be a "covered service" on the Schedule of Benefits** (i.e. one that would normally be covered for the client if one of the situations above did not apply to them)
- **The service must be medically necessary**
- **Clients should seek more efficient avenues of payment and coverage before sending bills to LA HAP for overages.** Examples:
    - We understand that many parishes are dental provider shortage areas which may make it difficult to locate in-network providers. However, clients who *do* have access to an in-network provider should not be visiting an out-of-network provider.
    - Clients who have non-emergency dental procedures scheduled near the end of their plan year which can reasonably be re-scheduled for the beginning of the next plan year (when their annual maximum and covered services reset) should do so.

On a case-by-case basis, LA HAP can also cover the cost of a service not on the insurer's Schedule of Benefits. The service must be deemed medically necessary per the client's dental care plan and the client must consult with LA HAP prior to receiving services if they intend to bill HIP.

Vision insurance: LA HAP will continue to follow the primary insurer's Schedule of Benefits and cannot cover overages for vision services or products.

We are grateful for your efforts helping your clients navigate their coverage responsibly in order to extend finite Ryan White resources. While this clarifies our current LA HAP policy regarding dental and vision care, we reserve the right to change policies in response to financial or other pressures placed upon our program. You will be informed by Bulletin of any policy changes.

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