Vantage is pleased to offer expanded dental coverage to members in 2017! Below are some frequently asked questions to help you understand our new dental coverage:

- **What levels of coverage are available?**
  - Preventive dental – routine exams and cleanings, basic preventive x-rays
  - Comprehensive dental – includes fillings, extractions, root canals, crowns, and other specified dental services

- **Which Vantage members have dental coverage for 2017?**
  
  **Commercial and Metal Plans:**
  - All Individual Marketplace/Exchange members have preventive and comprehensive coverage effective January 1, 2017.
  - All Office of Group Benefits (OGB or State Group) members have preventive and comprehensive coverage effective January 1, 2017.
  - Most Employer Group members will have preventive coverage as they renew in 2017. Groups have the option to select or reject comprehensive coverage at the time of renewal.

  **Medicare Advantage Plans:**
  - All Medicare Advantage members have preventive dental coverage effective January 1, 2017.
  - All Medicare Advantage members have comprehensive dental coverage effective January 1, 2017, except the Basic, Capitol, and OGB Zero Premium plans.

- **How can I tell which members have Comprehensive coverage?**
  - Look for the Vantage Dental logo on the front of the member ID card. If there is no Vantage Dental logo, the member only has preventive dental coverage.

- **What are the covered dental code categories?**
  - The code categories are: Preventive, Basic, Major, and Orthodontia.
  - Preventive coverage includes only the Preventive category. Comprehensive coverage includes the other three code categories.
  - A listing of the most frequently used covered dental codes by category can be found under the “Providers” tab at www.VantageHealthPlan.com, or by contacting Vantage.
  - In-network providers may access the Vantage Provider Portal for a full listing of covered codes. Please contact Provider Services at (318) 361-0900, option 3 for Provider Portal instructions.

- **How can I find the in-network fee schedule?**
  - Please contact Vantage’s Provider Services department at (318) 361-0900, option 3.

- **What is the Vantage member’s financial responsibility?**
  - Dental services are not subject to any deductible on any plan.
  - Preventive dental services are covered at 100% of the Vantage allowable.
  - Comprehensive dental member responsibility varies by member, plan, and dental code category. The attached Summary of Member Dental Cost Share can also be found in the Provider Portal or obtained by contacting Vantage’s Provider Services department.
• How does Vantage Dental coordinate with other dental supplemental policies?
  ➢ Standard coordination of benefit rules apply when determining the primary payor. Providers must submit an Explanation of Benefits (EOB) from the primary payor when submitting a claim to Vantage for coordination.
  ➢ It is the member’s responsibility to supply all dental coverage ID cards at the time of service.
  ➢ Vantage will not authorize dental services or return predetermination requests when Vantage is secondary.

• What covered services require pre-authorization?
  ➢ Out-of-Network: All services require pre-authorization.
  ➢ In-Network:
    1. Preventive Dental — No pre-authorization required.
    2. Basic Dental — No pre-authorization required.
    3. Major Dental — Pre-authorization required.
    4. Orthodontia — Pre-authorization required.

• How do I request a pre-determination or pre-authorization?
  ➢ Vantage’s Medical Management department can supply both pre-authorizations and pre-determinations.
    Dental pre-authorization and pre-determination requests can be submitted by telephone at (888) 823-1910, option 2 or by fax to (318) 361-2170.
  ➢ Pre-authorizations and pre-determinations are made available within 7 business days of Vantage’s receipt of the request and represent a member’s coverage at the time of creation.

• Why should I become a Participating Dental Provider?
  ➢ In-Network Providers enjoy access to the Provider Portal.
  ➢ Preventive and Basic dental services have no pre-authorization requirements for In-network Providers.
  ➢ In-Network Providers receive payment from Vantage usually within 14 days of receipt of a clean claim.

• How do I contract with Vantage?
  ➢ Contact Provider Services at (318) 361-0900, option 3, for more information about contracting with Vantage.
  ➢ Contracted Providers must agree to the Vantage Dental fee schedule and cannot balance bill members.

• What claim forms are accepted?
  ➢ Vantage accepts the 2012 American Dental Association claim form. The claim form can be accessed as follows:
    1. http://www.ada.org/~media/ADA/Member%20Center/Files/j430d_dental_claim_form_2012.pdf?la=en,
    2. On the Provider tab at www.VantageHealthPlan.com, or
    3. In the Provider Portal.
  ➢ Claim forms can be submitted to Vantage via mail or electronically. Vantage uses Change Healthcare as its clearinghouse for electronic claims.

• Who do I call for help?
  ➢ Vantage’s Provider Services department can be reached at (318) 361-0900, option 3. Provider Services can assist with contracting, claims, coding, and fee schedule questions.
  ➢ Vantage’s Member Services department can be reached at (318) 361-0900, option 1. Member Services can assist with eligibility, benefits, and claims status questions.
  ➢ Vantage’s Provider Networking department can assist with contracting and can be reached at (318) 998-3187 or busery@vhpla.com.
# Summary of Member Dental Cost Share

*Logo on ID Card denotes Comprehensive coverage. Not subject to any deductible.*

## Commercial Group Plans

<table>
<thead>
<tr>
<th>Code Category</th>
<th>In-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>100% Coverage of Vantage Allowable.</td>
</tr>
<tr>
<td>Basic</td>
<td>80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. <em>Maximum Vantage payment for combined Basic and Major is $1,500 per member.</em></td>
</tr>
<tr>
<td>Major</td>
<td>50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. <em>Maximum Vantage payment for combined Basic and Major is $1,500 per member.</em></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. <em>Maximum Vantage payment for cosmetic Orthodontia is $1,000 per member.</em></td>
</tr>
</tbody>
</table>

## Metal Tier (Marketplace/Exchange) and OGB Plans

<table>
<thead>
<tr>
<th>Code Category</th>
<th>In-Network Coverage</th>
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<tbody>
<tr>
<td>Preventive</td>
<td>100% Coverage of Vantage Allowable.</td>
</tr>
<tr>
<td>Basic</td>
<td>50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. <em>Maximum Vantage payment for combined Basic and Major is $500 per adult over age 18.</em></td>
</tr>
<tr>
<td>Major</td>
<td>50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. <em>Maximum Vantage payment for combined Basic and Major is $500 per adult over age 18.</em></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. <em>Coverage for medically necessary orthodontia only for children ages 18 and younger.</em></td>
</tr>
</tbody>
</table>

## All Individual and Employer Group Medicare Advantage Plans (except the three plans listed below)

<table>
<thead>
<tr>
<th>Code Category</th>
<th>In-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>100% Coverage of Vantage Allowable.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>100% Coverage of Vantage Allowable up to an annual dental maximum. Annual dental maximum varies by plan ($300 - $1,000).</td>
</tr>
</tbody>
</table>

## Basic, Capitol, and OGB Zero Premium Medicare Advantage Plans

<table>
<thead>
<tr>
<th>Code Category</th>
<th>In-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
<td>100% Coverage of Vantage Allowable.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>