Medicare & Individual Dental & Vision FAQs

This Frequently Asked Questions document outlines questions we commonly receive from agents. There are three sections:

→ **Section 1: Humana Medicare Advantage (MA) Mandatory Supplemental Benefits (MSB) and Optional Supplemental Benefits (OSB)**

→ **Section 2: Individual stand-alone dental and vision (IDV) benefits**

→ **Section 3: Agent and customer service support**

Tips:

- Agents can find a lot of information about Humana's dental and vision plans on **IgniteWithHumana.com**.
- Agents also have access to post-enrollment support through Vantage Service Inquiry.
    - Ask questions about how a member's claim was processed, check on the status of a claim or pre-treatment estimate, request an ID card or provider directory, or with a member's access to care (e.g., an in-network dentist isn't recognizing the plan; a member needs support finding an in network provider).

Here's what others are saying about Vantage Service Inquiry:

"The Vantage system for inquiries was phenomenal in providing answers."

"I very much appreciate everyone's work and assistance on making this right for our member. THIS is what I like to share with people – how we take care of our members properly."

"The member was amazed on how many times you reached out to her dentist when things did not feel like they were handled correctly. Thank you so much for helping her. She is now referring her friends and her son to Humana for our dental coverage."

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Section 1: Humana Medicare Advantage (MA) Mandatory Supplemental Benefits (MSB) and Optional Supplemental Benefits (OSB)

Control and right click on the topic to go directly to that section.

Section 2: Individual stand-alone dental and vision (IDV) benefits

2.1. Individual dental plans

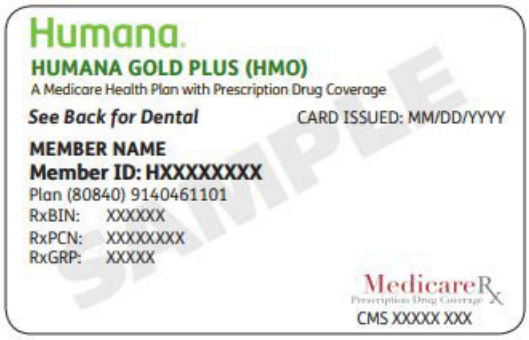
2.2. Individual vision plans

Section 3: Agent and customer service support

Section 1: Humana Medicare Advantage (MA) Mandatory Supplemental Benefits (MSB) and Optional Supplemental Benefits (OSB)

1.1.A. How to understand dental benefits on the MA ID card

The Medicare Advantage ID card includes information about the member's medical benefits on the front of the ID card and indicates information about the member's dental benefits on the back of the card.



In the above sample MA ID card image, HMO on the front of the ID card ONLY refers to the medical benefits. The dental benefits are NOT HMO. Those plans have in-network only dental benefits, but they use a network that dentists know as a PPO network. The name of the dental network is found on the DENxxx dental benefit descriptions found on **Humana.com/sb**. When your member contacts the dental office for an appointment, the member should say "I have dental benefits with my Humana Medicare Advantage plan. The dental benefits are provider by dentists in the (HumanaDental Medicare for all states except FL, or Florida GoldPlus for FL members) network". NOTE: Member flyers are available in the Marketing Resource Center (MRC) for agents to provide members with instructions (GHHKBVREN & FLHKBZBEN)

1.1.B. Detailed information on Humana's MA dental DENxxx benefits

Q: Where can an agent find information about the Dental DENxxx benefits?

A: The DENxxx, representing the dental benefits on a Medicare Advantage plan, are listed in multiple places: Medicare Advantage Product Document library, Medicare Advantage ID card, Medicare Advantage Summary of Benefits, Medicare Advantage Evidence of Coverage.

It is important to know that not all American Dental Association codes are covered on every DENxxx plan. Therefore agents should go to **Humana.com/sb** to find the specific DENxxx benefit descriptions.

If members call customer service, they are sent the DENxxx sheets. If a dentist calls provider customer service to verify benefit, they are sent the DENxxx sheets. Agents should reference those sheets, and give them to their members, so everyone has visibility of the details of what is covered. If a code is not listed in those DENxxx, then that service is not covered. Be sure to note submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Limitations and exclusions outlined in Evidence of Coverage (EOC) may apply.

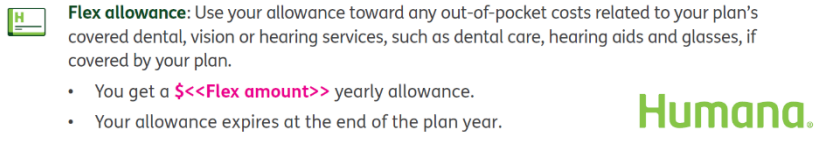
1.1.C. Flex allowance Dental/Vision/Hearing (D/V/H)

Q: How can members use their MA plan's embedded dental benefits (DENxxx) in addition to using their D/V/H Flex allowance on their Humana Spending Card (where applicable; not all MA plans have the D/V/H Flex allowance).

A: The easiest way to know if a Medicare Advantage plan features a Flex allowance is to check the "More Benefits" with your plan section in the plan's Summary of Benefits. Not all Medicare Advantage plans offer a D/V/H Flex allowance. For plans that do have Flex, the member will be mailed a Humana Spending Account card. Members who had a Flex allowance on their previous year's Humana plan will use the same Spending Account card and will only be sent a new card upon request. Allowance amounts vary by plan. Note: Members with a USA Health Flex Card from their 2023 Humana plan will be sent a Humana Spending Account card to access their 2024 Flex allowance and any other allowances which may be on the card.

The Flex allowance can be used on dental, vision and hearing services which are covered by the Medicare Advantage plan. For example, the Flex allowance can be used toward out-of-pocket expenses for the services listed in the DENxxx description.

The Humana Spending Account card carrier will indicate the D/V/H Flex allowance as shown below.



The card carrier is mailed to the member. It contains the Spending Account Card and important information about the Flex allowance (and any other allowance(s) which may be on the card).

The dental insurance benefit (DENxxx) is applied first, then the Flex allowance can be used for out-of-pocket expenses for covered services received in the current plan year. The dental office will first apply the Humana Medicare Advantage DENxxx benefits by submitting a claim to Humana. After that, any out-of-pocket costs remaining for those services can be paid for using the Flex allowance. The current year's Flex allowance should not be used to pay for balances on prior year's services. Flex allowance cannot be used towards Lasik and cannot be transferred to another family member.

Here are two examples:

Example #1: the member has covered fillings, and uses the MSB DENxxx for those fillings, but then hits their annual max of $1000. Member can then use their Flex allowance to pay toward this remaining out of pocket balance for covered services.

Example #2: the member has a vision allowance of $300 but selects glasses that cost $500. The provider applies the $300 allowance from VISxxx, then the member uses their Flex allowance toward the remaining $200 balance for the glasses.

1.1.D Dentures

Q: How does the 5-year frequency clause work with Dentures on the MA plans?

A: Many plans do have a frequency for dentures, such as coinsurance for an upper and lower denture every 5 years, considering services provided by Humana. For example, if a member received a new upper denture 2 years ago (while enrolled on a Humana plan), Humana would not cover a new upper denture until the 5-year period was up (3 more years in this example). However, if the MA member was not enrolled on a Humana plan and received the new upper denture on another carrier's plan, Humana would not consider that service towards the frequency limit. Also, if the member needed a new denture (one that they had never had before) there would be no waiting period.

Q: Is the Denture coverage in the Humana MA plans impacted by a missing tooth clause?

A: Humana Medicare Advantage plans are not subject to a missing tooth clause (even though many of our stand-alone individual plans have missing teeth clauses). Therefore, in the case of the Medicare Advantage dental benefit, even if the member's tooth was missing prior to purchasing the Humana Medicare Advantage plan, that member can still get dentures to replace that tooth (if dentures are a covered benefit in the plan, subject to limitations)

1.1.E. OSB or MSB dental benefits

Q: Where can you view benefit information for dental MSB and OSB?

A: Dental MSB and OSB benefit details (DENxxx) can be located at **Humana.com/sb**.

Q: Is the OSB in addition to the MSB? Or is it instead of the MSB?

A: The OSB, if purchased, is a replacement of the MSB. This is how it is described in the Medicare Advantage Summary of Benefits: "[…] is an optional supplemental benefit package (OSB) that can be purchased for an additional monthly premium to replace any routine dental benefits that are offered within your Medicare Advantage plan. If purchased, the OSB will entirely replace the dental coverage defined in your benefits package. This means, you should disregard any language in the Mandatory Supplemental Dental Benefit section contained in Chapter 4 of the EOC. When you enroll, you will receive a new ID card showing your new [DENXXX] listed on the back. Any claim paid under the current year Mandatory Supplemental Benefit will apply toward the annual OSB maximum plan benefit."

Q: How does the MSB and OSB maximum benefits work together?

Ex: If the member buys the OSB, do they get the $2,000 of the OSB and the $1,000 from the MSB?

A: All OSBs have annual maximums of $2,000. Once a member purchases an OSB, their new annual maximum will be $2,000.

Q: If MSB max benefit is already $2,000 what is the additional value to the member for

purchasing an OSB?

A: The OSB is always an enhancement from the MSB. Refer to the DENxxx sheets located at **Humana.com/sb** to compare the max benefits, covered services, and cost shares between an MSB and an OSB.

Q: If a member purchases an OSB, do previous claims on the dental MSB start over?

A: No, claims do not start over when purchasing an OSB. They will carry forward until the completion of the current calendar year.

Q: How do members pay for their OSB?

A: Members should use the same payment method that they use for the Medicare Advantage plans.

1.1.F. Adding and dropping OSBs

Q: How can a member add an OSB?

A: Members can add OSBs throughout the year. To add an OSB, the member's agent can use a paper application, or can enroll them through electronic sales tools; if a member calls customer care (on back of the ID card), they are routed to a Humana sales agent who can complete their OSB application by phone. It becomes effective the 1st of the following month, in general.

Note, the Humana Agent of Record (AOR) protection pledge protects AOR status when a like-to-like plan change is facilitated by a Humana telesales agent.

Q: How can a member drop their OSB coverage?

A: To drop an OSB, the member must call customer care at **888-413-7026** and they will be rerouted to the appropriate agent. They can term at the end of the current month from when the term request is received. To prevent a phone call, term requests can be faxed or mailed stating member name, address, Humana ID and request for cancellation.

Fax:
800-633-8188

Mail:
Humana
P.O. Box 14168
Lexington, KY 40512-4168

Q: I was told that the OSB DENxxx on my prior year MA plan is dropping, and a different OSB DENxxx is available for the upcoming year. What does that mean?

A: Changes in OSB offerings are possible every plan year. In some cases, an OSB is no longer offered because the embedded

(MSB) benefit for the new year has rich coverage. In other cases, an OSB is still offered, but with a different DENXXX from the prior year. In either case, the prior year's OSB will terminate on 12/31/XXXX, and the member will be notified in their Annual Notice of Change (ANOC) letter. If an OSB is still offered in the new plan year, the member must enroll in the new year's OSB offering if desired. As stated in ANOC:

"If you would like to explore OSB options for [the new plan year], please contact your agent at this time or call OSB sales on or after December 8, 2024, at **888-413-7026**."

1.1.G. Dental annual maximum of the MA plans

Q: How should an annual maximum of the MSB and OSB be understood?

A: A member will receive benefits until they reach the annual maximum of the plan. After that, the member is responsible for any services received. How services are applied to the annual maximum: For example, if a member has an extraction that is covered 100% by Humana, Humana will apply the value of those services to the annual maximum.

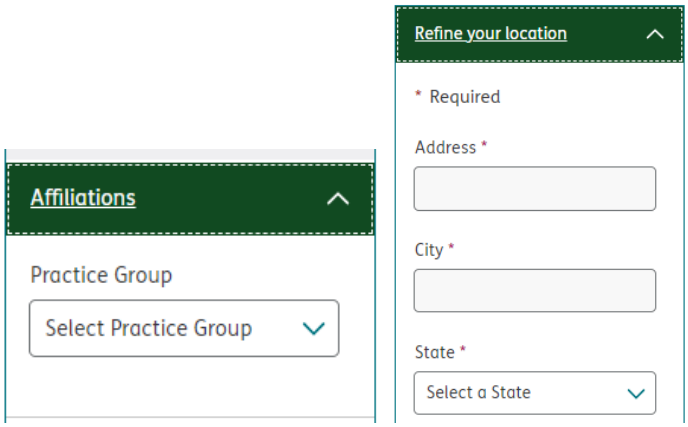
Q: If a member changes MA plans mid-year, does the dental annual max start over?

A: Any dental claims that a member has had in the calendar year stay on their record and go with them to the new plan. The annual maximum only starts over at the beginning of each calendar year.

1.1.H. Finding in-network dental providers for MSB and OSB

Q: How do I find an in-network dental provider for MSB and OSB dental?

A: The nationwide network for MSB and OSB will ALWAYS be Humana Dental Medicare network (the only exception is that the MA plans sold in Florida use the Florida GoldPlus nationwide dental network). The dental benefit may be in-network only, or it may have in- and-out-of-network benefits, but all MSB and OSB dental will use the networks mentioned above. The preferred place to locate in-network providers is in the **Humana.com** directory, from this page you will select "find care". Expert tip: The Affiliations filter in the search results will allow you to view all providers and locations affiliated with a particular office or group. You may also select "Refine your location" if you do not know the name of the provider but do know the office address.



1.1.I. Dental claims and out-of-network dental claims

Q: How long does it take for Humana to process MA dental claims?

A: Claims submitted with complete documentation process within 30 days; claims that require additional documentation may take up to 60 days.

Q: How do we submit an out-of-network MA dental claim?

A: Members may need to pay the dentist up front for services and then submit the claim to Humana if they take advantage of the out-of-network benefit. To submit an out of network claim, no specific form is required. The member will just send the itemized statement from the dentist with the information detailed below to the address on the back of the Medicare Advantage ID card. See more details in the OON claims flyer located on the member tab on **Humana.com/sb.**

- The patient's name and Humana member ID number on the itemized statement.
- It should include the dentist information (dentist full name and address) that performed the services, and ideally the dentist's TAX ID, which can be obtained from the dental office.
- The dentist should provide additional documentation that may be available if submitting for the following services: oral evaluations, periodontal scaling, fillings, crowns, implants, root canal, oral surgery, and crowns.
- The documentation should be clear and legible, and the member should keep a copy for their records.

Q: Out-of-Network (OON) Coverage: Many MSB or OSB plans cover services at 100% in-network and 100% out-of-network. How can we make sure that the member understands that the OON dentist could balance bill, so the member will likely have some charges?

A: It is always best to use in-network providers; if members use out-of-network providers they may be balanced billed for the difference in their charges and what Humana paid for that service.
This disclaimer appears in the summary of benefits, evidence of coverage and DENxxx sheets for plans with out-of-network benefits, indicating that there could be balanced billing:

Out-of-network dental providers have not agreed to provide services at contracted fees. Benefits received out-of-

network are subject to any in-network benefit maximums, limitations, and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider."

See more details in the OON claims flyer located on the "Members and Agents" tab on **Humana.com/sb.**

1.1.J. Routine Cleanings

Q: Is there a restriction on how much time may elapse between routine cleanings?

A: There is no restriction for the time that elapses between the member's routine cleanings (D1110).

Q: What is the difference between a routine cleaning and a "deep cleaning? "

A: Routine cleaning is a preventive service (D1110). Periodontal scaling is sometimes referred to as a "deep cleaning." Periodontal scaling (D4341 or D4342) is required when a patient has gum inflammation or gum disease or extensive plaque and is a major service. Once a patient has had periodontal scaling, then when they have their next cleaning, it will be periodontal maintenance (D4910).

1.1.K. Alternate benefit

Q: What is an "alternate benefit?"

A: For dental conditions that have two or more possible treatments, Humana will cover the lowest cost treatment, as long as it is proven to provide satisfactory results. If the member chooses to receive a higher cost treatment, they will be responsible for the difference.

1.1.L. Pretreatment Plan

Q: How can my member determine how much their dental treatment will cost them prior to the procedure?

A: If the dental care you need is expected to exceed $300, we suggest you or your dentist send a dental treatment plan for us to review ahead of time so that we can provide you with an estimate for services. Pretreatment plans are optional and never required by the plan.

The pretreatment plan should include:

1. A list of services you will receive, using American Dental Association nomenclature and codes.
2. Your dentist's written description of the proposed treatment.
3. X-rays that show your dental needs.
4. Itemized cost of the proposed treatment.
5. Any other diagnostic materials we request.

1.2.A. Vision provider directory

Q: For Medicare Plans that indicate EyeMed on the back of the member's ID card: How to find in-network providers for this EyeMed vision benefit.

A: It is extremely important to look in the correct directory. The preferred method to find routine vision providers for these plans is to use the **Humana.com** provider directory and look within the Vision section as indicated in the Evidence of Coverage. Educational flyers available (see section 1.2.B).

Q: Provider directory for MA plans that do not indicate EyeMed on the back of the ID card

A: The best way to find the in-network routine vision providers for these plans is to look in the medical directory of the Medicare Advantage plan. Educational flyers available. See section 1.2.B.

1.2.B. Vision benefits

Q: What is the difference between the medical vision benefit and the routine vision benefit?

A: We have flyers outlining the difference located in the MRC.

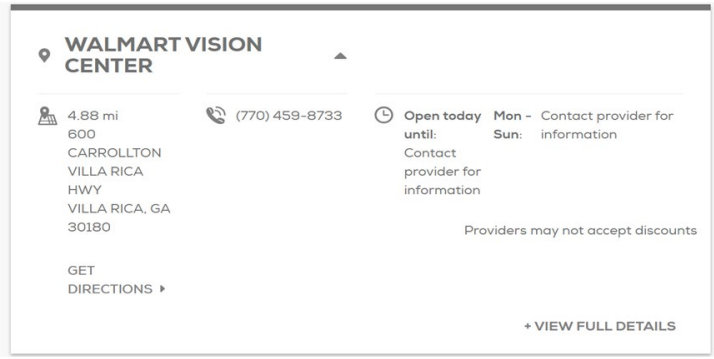
- 2024 Medicare Advantage - How to use Vision benefit - All states except FL TX LA (MRC document # GHHM3X3EN)
- 2024 Medicare Advantage - How to use Vision benefit - Florida Only (MRC document # FLHM3X6EN)
- 2024 Medicare Advantage - How to use Vision benefit - Louisiana and Texas Only (MRC # GHHLGEHEN)

Q: What is the PLUS vision benefits on some Medicare Advantage plans?

A: Some Medicare Advantage plans offer an additional $50 towards the purchase of frames and lenses or towards the purchase of contact lenses when visiting a PLUS provider. The Summary of Benefits will indicate if this benefit is available on a specific MA plan.

Q: Are Vision Providers in Walmart locations in network? (This pertains to EyeMed plans only)

A: Doctors in Walmart locations are independent. We estimate that approximately 60% of the doctors in those locations are contracted for the vision network. For locations where the doctor is not in network it will appear as greyed out in the Vision directory (screen shot below from the Vision directory), the store location is still in network for glasses/contacts.



1.2.C. Out-of-network vision claims

Q: How do we submit an out-of-network claim for the EyeMed vision plans?

A: To receive out-of-network vision benefits (if the member's plan includes OON vision benefits), the member would need to pay services to the out-of-network vision provider, and then submit a receipt together with the **Humana EyeMed** OON vision claim form. The address where the claim should be mailed to is indicated on that form. The member can find the claim form posted on their secure **MyHumana.com** site.

Section 2: Individual stand-alone dental and vision (IDV) benefits

2.1. Individual dental plans

2.1.A. Dental member ID card

Q: What do members receive upon enrollment in the plan?

A: We request that agents capture the applicant's email in the application; within 3 days of processing their application, we send new members an email including their member ID and a link to their Summary of Benefits, allowing them to log on to **HumanaOneMembers.com** to find their plan documents (Policy, ID card). An ID card is also sent in the mail approximately 7 days after enrollment.

Here is an example of an individual dental ID card. Note: The ID card details may vary by plan and by state.

Q: Who is listed on the ID card?

A: Only the primary subscriber is listed on the ID card; the names of the dependents are not listed on the ID card, but are listed in the Policy, found in the secure member portal **HumanaOneMembers.com**.

2.1.B. Detailed information about individual dental plan benefits

Q: Where agents can find plan information

A: Find out which individual Specialty Plans are in your area with the **Individual Specialty Agent Plan Grid**, available on **IgniteWithHumana.com**, which includes state-specific Benefit Summaries as well as Rate Sheets. The plan grid is also found on Vantage.

Q: Some of the rate sheets indicate that there is a $1.00/mo. association fee. What is that for?

A: Some of Humana's dental and vision plans are filed under the People's Benefit Alliance (PBA), and therefore association membership is required to enroll in those dental and vision plans; PBA is a not-for-profit membership organization that enables Humana the ability to more effectively provide insurance options to consumers. Other benefits provided through

the PBA membership include educational information and discounts on health, travel, consumer and business-related goods and services. More information is available at **peoplesbenefitalliance.com**.

2.1.C. Limitations such as the missing tooth clause and frequency limitations

Q: How does the missing tooth clause work for the individual dental plans?

A: Humana's Individual dental plans have a missing tooth clause, as stated in the Summary of Benefits.

"Replacement of congenitally missing teeth or teeth extracted prior to coverage under the policy are not covered."

It means that a new prosthesis that replaces teeth (such as denture or implant) can only be covered when the tooth went missing while on the specific individual dental plan.

Here is an example of what our Complete Dental member certificate states about missing teeth:

*"Initial placement of full and partial dentures o**nly if the functioning tooth** (excluding third molars or teeth not fully in occlusion with an opposing tooth or prosthesis) **was extracted while you are covered under this policy**. Covered services include retainer inlays, retainer onlays, and retainer crowns. Covered expense includes removable partial dentures and full dentures. Initial placement includes all adjustments and relines within six months after installation and are payable only for treatment on permanent teeth. **We will not cover replacement of congenitally missing teeth."***

Q: What happens when a person already has a denture or implant? Does the missing tooth clause still apply?

A: When a person already has a prosthesis in place (such as a denture or implant) then getting a new denture or implant would be considered as a replacement and the frequency limitations apply. This is how it is stated in the Humana Extend 5000 Policy.

"Implants and implant supported prostheses covered under this plan are limited to the replacement of permanent teeth extracted while insured under this plan, or for replacement of a prior prosthesis if it has been at least five years since the prior insertion, and is not, and cannot be made serviceable."

Q: How does the 5-year frequency clause work on the individual dental plans?

A: Many plans do have a frequency limitation for dentures, such as coinsurance for an upper and lower denture every 5 years, considering services provided by Humana. For example, if a member received a new upper denture 2 years ago, Humana would not cover a new upper denture until the 5-year period was up (3 more years in this example). Humana will update the individual member's tooth history, whether the current denture was paid for by Humana, or another insurer or paid by the member themselves.

2.1.D. Routine cleanings

Q: Is there a restriction on how much time may elapse between routine cleanings?

A: There is no restriction for the time that elapses between the member's routine cleanings (D1110).

Q: What is the difference between a routine cleaning and a "deep cleaning"?

A: Routine cleaning is a preventive service. Periodontal scaling is sometimes referred to as a "deep cleaning." Periodontal scaling is required when a patient has gum inflammation or gum disease or extensive plaque and is a major service. Once a patient has had periodontal scaling, then when they have their next cleaning, it will be periodontal maintenance.

2.1.E. Alternate benefits

Q: Please explain alternate benefits.

A: There is a note on the Summary of Benefits when an alternate benefit applies. Here is an example from Loyalty Plus:

"Composite (white) fillings are only covered on anterior (front) teeth. An alternate benefit is allowed for composite fillings on posterior (back) teeth where the plan will cover the cost of an amalgam (silver) filling and the member is responsible for any cost over the covered amount."

2.1.F. Waiving of waiting periods

Q: Which plans allow for waiving of the waiting periods.

A: The applications for Complete Dental and Humana Extend 5000 include 5 questions to gather information on a member's prior coverage; that is the information that is used to determine if the waiting periods (basic and major) could be waived. Creditable coverage would be dental insurance for the past 12 months, with a lapse of no more than 63 days (between the time the prior coverage dropped to the effective date of the new plan). Note: In the case of Humana Extend, the implant waiting periods cannot be waived.

The prior dental insurance may have provided benefits for Preventive + Basic services (such as our Preventive Plus plan) OR provided coverage for Preventive + Basic + Major services (such as group dental plans). The following types of plans are not considered prior creditable coverage: Preventive Only coverage, Discount Plans, MSB Plans (embedded dental benefits in a Medicare Advantage plan, since there is no separate dental premium).

2.1.G. Dental provider directory

Q: Which provider directory should I use?

A: The preferred place to locate in-network providers is in the **Humana.com/Find-Care** directory. You can also find a link to the dental provider directory within Vantage. Expert tip: The Affiliations filter in the search results will allow you to view all providers and locations affiliated with a particular office or group. You may also select "Refine your location" if you do not

know the name of the provider but do know the office address.

2.1.H. Dental enrollment

Q: Where can agents complete enrollments for Humana's on-exchange Smart Choice dental plans.

A: Enrollment occurs through Healthcare.gov. Once the agent or applicant gets to the payment method on the application, they will be connected to Humana's Online Billing Portal (OHBP), so the applicant can pay electronically. Members can update billing information on the secure member portal **MyHumana.com.**

Q: Where can agents complete enrollments for the rest of our individual dental plans?

A: Agents can complete electronic applications in Enrollment Hub (Ehub), found on Vantage:

- When you open Ehub, it asks for Scope of Appointment (SOA). That is not required for individual dental and vision, so you can skip that.
- Generate a Quote, inputting prospects demographics and then selecting a plan (dental, dental/vision/hearing or vision).
- Continue within Ehub to complete the application. Alternatives for signature are Phone signature or Text Signature.

In addition, we encourage agents to set up their webpage using the Agent Online Application (AOA) link. Send this link to customers or prospects; then the individual can self-enroll online, listing that agent as the Agent of Record. Create the AOA link including the agent ID number (also referred to as SAN): *Humana.com/aoadv/7-digit-SAN*

Plan changes require the use of paper applications, which can be found in the Marketing Resource Center (MRC).

Q: Are common law marriages and same sex marriages eligible to enroll in an IDV plan together?

A: Humana allows domestic partners (e.g., same gender partners) to enroll in an IDV plan together; this is for all states regardless of whether the state recognizes domestic partners. In June 2015 the Supreme Court ruled that same gender partners have the same rights as any married couple–this is a federal ruling that trumps any state specific law.

Q: Can a non-US citizen, or a person without a Social Security Number (SSN), enroll in our IDV plans?

A: Yes. Though, some of our enrollment systems still require the SSN. To move beyond the required SSN field(s) in the electronic or paper application, the following entries can be utilized for the primary applicant and any dependents, using a different entry for each individual included on the application.

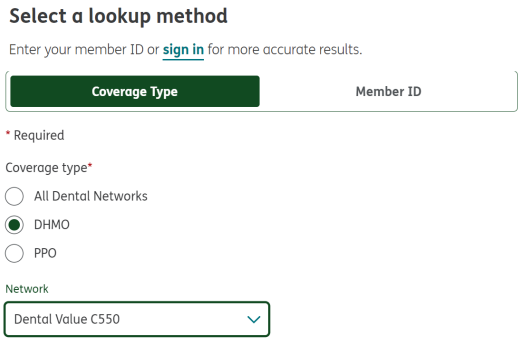
Policy Holder SSN: 111-11-1111
Spouse SSN: 222-22-2222
Dependent 1 SSN: 333-33-3333
Dependent 2 SSN: 444-44-4444
Continue the number logic for additional dependents, as needed.

Q: How to choose a Primary Care Dentist for the Dental Value HI215 or Dental Value C550 DHMO.

A: The primary care dentist must be a general dentist and must be located in the same state where the member's plan is being purchased. In order to use the Dental Value plan, the member must be added to the roster of the primary care dentist (which is achieved by including that information in the application for the plan).

Key steps when searching for a primary care dentist.

- Start by accessing the **Humana.com/Find-Care** directory.
- Indicate DHMO coverage type and choose the Dental Value C550 or the Dental Value HI215 networks (the plan name varies by state).



- Now you will be on a new provider directory screen. You will need to once again input the zip and choose the C550 or HI215 network.

If a change to a primary care dentist is desired, the member can request that change on **HumanaOneMembers.com** or can call Customer Service.

Q: Can a parent buy a plan for a child?

A: Yes, a parent or custodian can buy a plan for a child. The plan should reflect the address where the child's main residence is. If there are two or more children on a plan, the youngest is the primary, and the rest are dependents.

Q: What are the maximum ages of dependents?

A: In most states, the maximum age for a dependent is up to 26 years of age. However, some states allow dependents to be over the age of twenty-six.

Q: I am on an individual dental plan but I am moving to a different state. What do I need to do?

A: You need to call Customer Service (phone on the back of the ID card) and ask for assistance changing to a plan in your new state. Plans and rates are state specific. You have 30 days from when you move to complete this plan-to-plan change.

2.1.I. Dental effective dates and payment dates

Q: How are the effective dates calculated?

A: Individual stand-alone plans can be quoted up to 90 calendar days for a future effective date. PPO plans can have an effective date as soon as 5 days after the enrollment is received and the initial payment is processed. However, DHMO plans (Dental Value - H1215 or C550) can only have a first-of-the-month effective date, and initial payment must be received no later than the 15th of the month prior to the requested effective date. Applications for DHMO plans received the 16th through the end of the month will be effective the first of the subsequent month. (Ex: application received on July 16 can be effective September 1).

Q: What are the choices for effective date and payment dates for the PPO individual dental plans?

A: The effective date can be as soon as 5 days, or as far out as 90 days, from the date the application is processed.
The first payment made is for one month of coverage (or 1-year if annual billing) and includes the enrollment fee (if applicable). The initial payment date selected must be at least 5 calendar days before the plan's effective date.

- **Recurring Payment Methods:** The member may choose one of these dates for their recurring payment: the 5th, 15th or 25th. Members pay one month in advance.

Note 1: The applicant may have both initial payment and 2nd payment come out in the same month, depending on the date of the initial payment, and the date chosen for the recurring payment.
Here is an example:

If a plan application is processed on September 1st, and the member chose the 15th of the month billing, the member would be billed the second month of premium (minus any prorated excess from month 1) on September 15th.

Note 2: The value of the 2nd payment may differ from the initial and subsequent payments. It may be the equivalent of 1 month minus the prorated excess, as shown above. Or it may be the equivalent of 2 months, minus the prorated excess as shown below:

The customer has an effective date of October 10th and had completed the application on October 5th. They selected the 5th

day of the month for their recurring payments. Their initial payment would be applied to the month of October. Since all premiums are paid in advance, on November 5th, the customer would be charged for the month of December, and also for the missed month of November, minus the carryover credit from October.

2.1.J. Pretreatment Plan

Q: How can my member determine how much their dental treatment will cost them prior to the procedure?

A: If the dental care needed is expected to exceed $300, we suggest the member, or the dentist send a dental treatment plan for us to review ahead of time so that we can provide an estimate for services. Pretreatment plans are optional and never required by the plan.

The pretreatment plan should include:

1. A list of services to be performed, using American Dental Association nomenclature and codes.
2. A written description from the dentist of the proposed treatment.
3. X-rays that show the dental needs.
4. Itemized cost of the proposed treatment.
5. Any other diagnostic materials we request.

2.1.K. Dental claims

Q: How long does it take for Humana to process individual dental claims?

A: Claims submitted with complete documentation process within 30 days; claims that require additional documentation may take up to 60 days.

Q: How are in-network dental claims filed?

A: The in-network dentist will submit claims to Humana for covered services, and the dentist can bill the member the remaining balance after the claim has been processed. Dentists may charge up front for non-covered services.

Q: How do we submit an out-of-network individual dental claim?

A: Members may need to pay the dentist up front for services and then submit the claim to Humana if they take advantage of the out-of-network benefit. To submit an out-of-network claim, no specific form is required. The member will just send the itemized statement from the dentist with the information detailed below to the address on the back of the member's ID card.

- The patient's name and Humana member ID number on the itemized statement.

- It should include the dentist information (dentist full name and address) that performed the services, and ideally the dentist's TAX ID, which can be obtained from the dental office.
- The dentist should provide additional documentation that may be available if submitting for the following services: oral evaluations, periodontal scaling, fillings, crowns, implants, root canal, oral surgery, and crowns.
- The documentation should be clear and legible, and the member should keep a copy for their records.

Q: Out-of-Network (OON) Coverage: Many plans cover services at 100% in-network and 100% out-of-network. How can we make sure that the member understands that the OON dentist could balance bill, so the member will likely have some charges?

A: It is always best to use in-network providers; if members use out-of-network providers they may be balanced billed for the difference in their charges and what Humana paid for that service.
This disclaimer appears in the Summary of Benefits indicating that there could be balanced billing:

"Out-of-network dentists can bill you for charges above the amount covered by your Humana Dental plan. To ensure you do not receive additional charges, visit a dentist in our nationwide network."

2.1.L. Changing or cancelling a dental plan

Q: How can a member modify their individual dental plan?

A: To modify a stand-alone dental plan (such as changing from Preventive Plus dental to Humana Extend), it is necessary to fill out a paper application and indicate "modification of coverage" at the top of the application. This way, a new enrollment fee will not be required, if applicable to the newly selected plan. Also, our enrollment system will know to issue the new plan and to halt the prior plan. You can access the paper applications via the Marketing Resource Center (Agent Materials). Refer to the Appendix within the **Individual Specialty Agent Plan Grid** for paper applicable form numbers, specific to the plan and state."

Q: How can a member cancel their individual dental plan?

A: The member should call Dental Customer Service (phone number on back of ID card) to cancel the policy, explaining the reason for cancellation, and customer service will evaluate the termination request. Note: Members may have a minimum 1-year contract on their plan. The agent of record can also submit a cancellation request on the member's behalf through a Vantage service inquiry.

Note: In the case of Smart Choice on-exchange dental plans, enrollment and disenrollment occur through the exchange (such as Healthcare.gov).

2.2 Individual vision plans

2.2.A. Vision member ID card

Q: What do members receive upon enrollment in the plan?

A: We request that agents capture the applicant's email in the application; within 3 days of processing their application, we send new members an email including their member ID and a link to their Summary of Benefits, allowing them to log on to **HumanaOneMembers.com** to find their plan documents (Policy, ID card). An ID card is also sent in the mail approximately 7 days after enrollment.

Here is an example of an individual vision ID card. Note: The ID card details may vary by plan and by state.

Q: Who is listed on the ID card?

A: Only the primary subscriber is listed on the ID card; the names of the dependents are not listed on the ID card, but are listed in the Policy, found in the secure member portal **HumanaOneMembers.com.**

2.2.B. Detailed information about individual vision plans

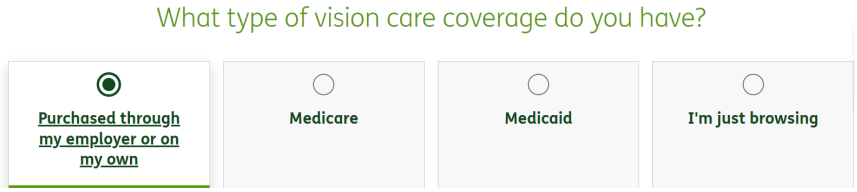
Q: Where agents can find plan information

A: Find out which individual Specialty Plans are in your area with the **Individual Specialty Agent Plan Grid**, available on **IgniteWithHumana.com**, which includes state-specific Benefit Summaries as well as Rate Sheets. The plan grid is also found on Vantage.

2.2.C. Vision Provider Directory

Q. Which provider directory should I use?

A: The preferred place to locate in-network providers is in the **Humana.com/Find-Care** directory, then look for the vision directory for the individual plan you are interested in (plans vary by state).



Next you pick the plan name based on which plan is available (there is only one individual vision plan per state).

2.2.D. Vision enrollment

Q: Where can agents complete enrollments for the rest of our individual vision plans?

A: Agents can complete electronic applications in Enrollment Hub (Ehub), found on Vantage:

- When you open Ehub, it asks for Scope of Appointment (SOA). That is not required for individual dental and vision, so you can skip that.
- Generate a Quote, inputting prospects demographics and then selecting a plan (dental, dental/vision/hearing or vision).
- Continue within Ehub to complete the application. Alternatives for signature are Phone signature or Text Signature.

In addition, we encourage agents to set up their webpage using the Agent Online Application (AOA) link. Send this link to customers or prospects; then the individual can self-enroll online, listing that agent as the Agent of Record. Create the AOA link including the agent ID number (also referred to as SAN): Humana.com/aoadv/7-digit-SAN

Plan changes require the use of paper applications, which can be found in the Marketing Resource Center (MRC).

Q: Are common law marriages and same sex marriages eligible to enroll in an IDV plan together?

A: Humana allows domestic partners (e.g., same gender partners) to enroll in an IDV plan together; this is for all states regardless of whether the state recognizes domestic partners. In June 2015 the Supreme Court ruled that same gender partners have the same rights as any married couple-this is a federal ruling that trumps any state specific law.

Q: Can a non-US citizen, or a person without a Social Security Number (SSN), enroll in our IDV plans?

A: Yes. Though, some of our enrollment systems still require the SSN. To move beyond the required SSN field(s) in the electronic or paper application, the following entries can be utilized for the primary applicant and any dependents, using a different entry for each individual included on the application.

Policy Holder SSN: 111-11-1111
Spouse SSN: 222-22-2222
Dependent 1 SSN: 333-33-3333
Dependent 2 SSN: 444-44-4444
Continue the number logic for additional dependents, as needed.

Q: Can a parent buy a plan for a child?

A: Yes, a parent or custodian can buy a plan for a child. The plan should reflect the address where the child's main residence is. If there are 2 or more children on a plan, the oldest is the primary, and the rest are dependents.

Q: What are the maximum ages of dependents?

A: In most states, the maximum age for a dependent is up to 26 years of age. However, some states allow dependents to be over the age of 26.

Q: I am on an individual vision plan but I'm moving to a different state. What do I need to do?

A: You need to call Customer Service (phone on the back of the ID card) and ask for assistance changing to a plan in your new state. Plans and rates are state specific. You have 30 days from when you move to complete this plan-to-plan change.

2.2.E. Vision effective dates and payment dates

Q: How are the effective dates calculated?

A: Individual stand-alone plans can be quoted up to 90 calendar days for a future effective date.

Q: What are the choices for effective date and payment dates for the PPO vision plans?

A: The effective date can be as soon as 5 days, or as far out as 90 days, from the date the application is processed. The first payment made is for one month of coverage (or 1-year if annual billing) and includes the enrollment fee (if applicable). The initial payment date selected must be at least 5 calendar days before the plan's effective date.

Recurring Payment Methods: The member may choose one of these dates for their recurring payment: the 5th, 15th or 25th. Members pay one month in advance.

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The customer has an effective date of October 10th and had completed the application on October 5th. They selected the 5th day of the month for their recurring payments. Their initial payment would be applied to the month of October. Since all premiums are paid in advance, on November 5th, the customer would be charged for the month of December, and also for the missed month of November, minus the carryover credit from October.

2.2.F. Vision Claims

Q: How are in-network vision claims filed?

A: The in-network providers search with their online system to verify the member's benefits, and the vision providers apply the benefits when the services are rendered. Separate in-network claims are generally not required.

Q: How to file out-of-network (OON) claims for individual vision?

A: To receive OON vision benefits (if the member's plan includes OON vision benefits), the member would need to pay for the services to the out-of-network vision provider, and then submit a receipt together with the **Humana OON vision claim form.** The address where the claim should be mailed to is indicated on that form.

2.2.G. Cancelling a vision plan

Q: How can a member cancel their individual vision plan?

A: The member starts by calling Vision Customer Service (phone number on back of ID card) to cancel the policy. EyeMed will transfer the call to Humana's Billing/Enrollment department to evaluate the cancellation request. Agents can also request this through a Vantage service inquiry.

Note: Members may have a minimum 1-year contract on their plan.

Section 3 - Agent and customer service support

Q: Where can agents get pre-enrollment assistance?

A: Agents can contact Agent Support (ASU) for pre-enrollment issues like application issues and enrollment status checks. You can reach them by phone at **800-309-3163** or email agentsupport@humana.com.

Q: Where can agents get post-enrollment assistance?

A: Agents can submit a Vantage Service Inquiry to request assistance for individual dental/vision as well as Medicare Advantage dental/vision. These may include asking questions about how a member's claim was processed, checking on the status of a claim or pre-treatment estimate, requesting an ID card or provider directory, or requesting assistance with a member's access to care (e.g., an in-network dentist isn't recognizing the plan; a member needs support finding an in- network provider). Be certain to select the dental/vision box when submitting the Vantage Inquiry.

Q: What document is required for Humana to speak to a caregiver, rather than the member?

A: The member should complete the Protected Health Information (PHI) release form: **Humana.com/caring-for-others/caregiver-access-to-protected-health-information**).