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)**

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

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

Tips:

- Agents can find information about Humana's dental and vision plans on **IgniteWithHumana.com.**
- Agents also have access to post-enrollment support through Vantage Service Inquiry. Be sure to check the dental/vision box so it is routed to the correct team.
    - 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."

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

Control and left 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

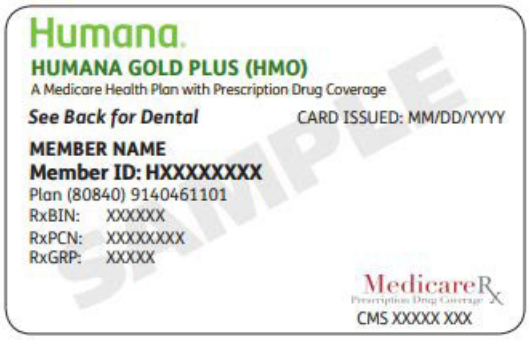
2.2. Individual vision plans

Section 3: Agent and customer service support

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

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 the member contacts the dental office for an appointment, the member should say "My dental benefits are included within my Humana Medicare Advantage plan. The dental benefits are provided by dentists in the HumanaDental Medicare PPO network (or in the case of Florida, indicate the network is the Florida GoldPlus 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.

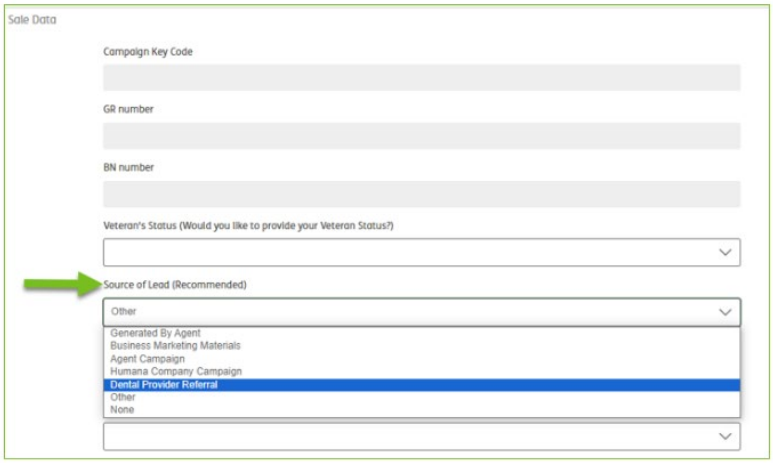
It is important to know that not all American Dental Association codes are covered on every DENxxx plan. Therefore agents should go to Humana.com/sb to find the specific DENxxx benefit descriptions.

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. Tracking Sales in Enrollment Hub and Sunfire

Q: Can I, an agent, accept referrals from a dental office?

A: A dental provider cannot give you patient information, however, they can share your contact details with patients who may be looking for insurance. If an enrollment is generated from a dental office, you can select "dental provider referral" as source of lead in the Enrollment Hub and in Sunfire.



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: Would the 5-year frequency clause apply if a member switches from a CarePlus MA plan to a Humana MA plan? What if they switch from a Humana MA plan to a CarePlus MA plan?

A: Frequency limitations on the client's new plan would consider services they received while enrolled in a CarePlus MA plan. The same is true when switching from a Humana MA to a CarePlus MA. Note, some plans may not include any frequency limitations for covered services. For more information, visit **Humana.com/sb**.

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)

Q: If a member's dentures are lost or stolen, will Humana replace them?

A: Unfortunately, no. Humana MA plans will not replace a member's dentures that are lost or stolen.

1.1.E. MSB dental benefits

Q: Where can you view benefit information for dental MSB

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

Q: If a member switches from a CarePlus MA plan to a Humana MA plan do claims start over?

A: No, claims do not start over when switching from CarePlus to Humana, or vice versa. The claims for the calendar year will carry forward. Claims reset on Jan 1st of the following year.

1.1.F. Dental annual maximum of the MA plans

Q: How should an annual maximum of the MSB 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.

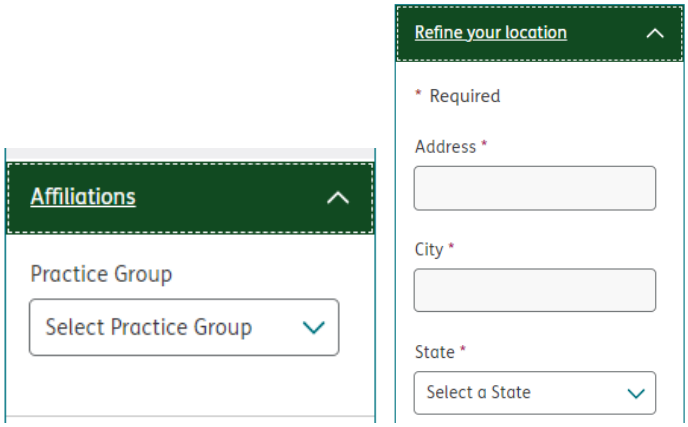
Q: If a member changes MA plans mid-year, does the dental annual max start over?

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.G. Finding in-network dental providers for MSB

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

A: The nationwide network for MSB 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 dental will use the networks mentioned above. 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.



1.1.H. 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 Members and Agents 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 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.I. 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.J. Pretreatment Plan

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

A: If the dental care the member needs is expected to exceed $300, we suggest the member's dentist send a dental treatment plan for Humana to review ahead of time so that we can provide the member 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 the member will receive, using American Dental Association nomenclature and codes
2. The dentist's written description of the proposed treatment

3. X-rays that show the member's dental needs
4. Itemized cost of the proposed treatment
5. Any other diagnostic materials as requested

NOTE: When a dental provider contacts the Humana provider services number to verify the member's DENxxx plan as active, the information provided on the phone call is NOT an actual pretreatment estimate rather a verification of benefits that may be available on that member's plan.

1.1.K. Crown and core build up claims

Q: Why was the member's crown or core build up dental claim denied by the provider even though the ADA code is covered on the DENxxx plan? Example: ADA codes D2790, D2950.

A: Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Humana will not cover any services related to replacing tooth structure as a result of abrasion, attrition, erosion or abfraction. For a full list of limitation and exclusions, see the Evidence of Coverage. A pretreatment plan can be requested prior to services being rendered to confirm eligibility of benefits.

- Any service related to:
  - Altering vertical dimension of teeth.
  - Restoration or maintenance of occlusion.
  - Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth.
  - Replacing tooth structures lost as a result of abrasion, attrition, erosion or abfraction.
  - Bite registration or bite analysis.

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/Find-Care** 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.

- Medicare Advantage - How to use Vision benefit - All states except FL TX LA (MRC document # GHHM3X3EN)

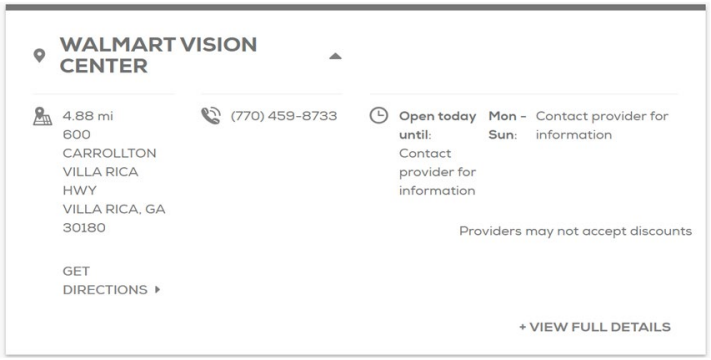
- Medicare Advantage - How to use Vision benefit - Florida Only (MRC document # FLHM3X6EN)
- Medicare Advantage - How to use Vision benefit - Louisiana and Texas Only (MRC # GHHLGEHEN)

Q: What is the PLUS vision benefit 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.



Q: Does the member's MAPD plan cover progressive/transitions lens?

A: Yes, members who have vision coverage on their MA plan can use their vision allowance towards lens that are progressive lens that will go towards their annual max vision allowance

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.

1.3.A. Members needing additional coverage

Q: A member needs more coverage than their MAPD plan has. How can I help the member obtain additional coverage?

A: Individual standalone dental and vision (IDV) plans are NOT Medicare polices but they can be sold to Medicare Advantage members wanting additional coverage. When presenting IDV to a MAPD member agents must present the complete IDV plan presentation to the member and at a minimum ensure the following:

- The agent is compliant with applicable state producer licensing, line of authority, and appointment requirements.
- Individual dental and/or vision plan discussion is properly identified on the Scope of Appointment (SOA) prior to discussion.
- It is made clear to the member that the individual plan is NOT a MA plan.
- It is made clear to the member that they do not have to enroll in the individual plan in order to keep their existing MA/MAPD plan.
- It is made clear that individual plan has a separate and additional premium, as is a completely separate plan with different requirements.

If	Then
You meet someone who needs dental or vision coverage.	An IDV plan could be a good fit. Since IDV is not a Medicare product, you do not need a Scope of Appointment (SOA) unless you will also be discussing a Medicare product.
A Medicare member in your book of business contacts you to discuss adding more dental coverage.	You should indicate on the SOA that IDV products will be discussed.
You are working with a prospective MA client. They've found an MAPD plan that suits their needs, but they need more dental.	An IDV plan can be purchased. If they would like to hear about those options, you'll need a new SOA indicating IDV is being discussed.
You see an MAPD client in your book of business is losing their OSB in the new year. You want to connect with them to make sure their dental needs are still being met.	If you have permission to contact the member, you can make the outreach but you must make it clear to them that the member does not need to enroll into an IDV plan in order to "stay in their Humana plan." You should indicate on your SOA that IDV products will be discussed.
You have an MA client who chooses to enroll in a Humana IDV plan.	Prepare your clients for how to use their benefits and find member-facing flyers in the **Marketing Resource Center (MRC).** You should indicate on your SOA that IDV products will be discussed.

Section 2: Individual Dental and Vision (IDV) Plans

2.1. Individual dental plans

2.1.A. Dental member ID card

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

A: Agents should capture the applicant's email in the application; within 3 days of processing their application, we send new members an email with 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 7-10 days after enrollment.

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 plans & benefits

Q: Where agents can find plan information

A: Find out which individual IDV Plans are in your area with the **IDV 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 **www.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."***

NOTE: There is no missing tooth clause on Dental Value/DHMO plans. However, this does not cover replacing tooth structure lost as a result of wear (abrasion, attrition, erosion or abfraction).

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 & AOA link

Q: Who can enroll in IDV plans?

A: Anyone of any age can enroll in dental, vision and DVH (Humana Extend) plans. Parents and guardians can enroll children in any Humana IDV plan without enrolling themselves (note: parents may have dental/vision benefits at work, but there may be no family plan offered, necessitating a stand-alone plan for children).

Q: How can prospects enroll in IDV plans after speaking with an Agent?

A: **AGENT ONLINE APPLICATION (AOA)** Agents can use the AOA link to close business if a member chooses to enroll at a later time. Send the AOA link to 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*

Q: Where can agents complete enrollments for Humana’s On Exchange dental plans offered through the Federally Facilitate or State-Based Health Exchange?

A: Enrollment occurs through **www.Healthcare.gov** or a State-Based Health Exchange website (varies by state). 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 to complete enrollment.

Thereafter, 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, found on Vantage:

- When you open Enrollment Hub, 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 select a plan (dental, dental/vision/hearing or vision).
- Continue within Enrollment hub to complete the application. Alternatives for signature are Phone signature or Text Signature.

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 supersedes 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.

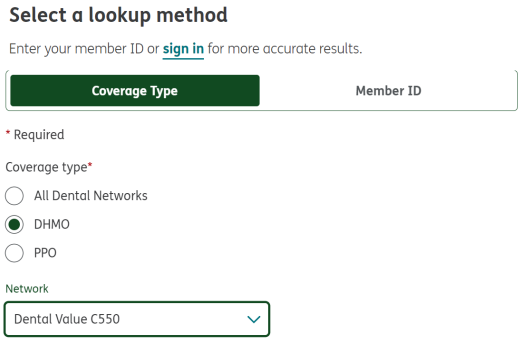
Policy Holder SSN: 111-11-1111
Spouse SSN: 222-22-2222
Dependent 1 SSN: 333-33-3333
Dependent 2 SSN: 444-44-4444
Continue the number logic for additional dependents, as needed.

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 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).



- You will see a new provider directory screen. Enter zip code 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: What is covered under the Dental Savings Plan?

A: The Dental Savings plan is not insurance, but a discount-only plan. There are no waiting periods, no plan limits or claims to file. The member goes to a Humana in-network provider, who will offer discounts on services and procedures. The discount percentage is dependent on the provider and is discussed and agreed upon between the provider and the member.

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, for example, if they are permanently disabled.

Q: The member is enrolled on an individual dental plan, and they are moving to a different state. What do they need to do?

A: Members can call Customer Service (phone number on the back of the ID card) and ask for assistance changing to a plan in their new state. Plans and rates are state specific. Members should complete this plan-to-plan change within 30 days of moving.

2.1.I. Dental effective dates and payment dates

Q: How are the effective dates calculated?

A: Dental Value - H1215 or C550 (DHMO plans) 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. If an application is received prior to the 15th of the month, the effective date is the 1st of the following month. If the application is received after the 15th of the month, the effective date will be the 1st of the subsequent month. E.g., application received on July 16 can be effective Sept. 1.

All other IDV plans: the effective date can be as soon as 5 calendar days after the initial payment and application have been received, or as far out as 90 calendar days from date of application.

Q: What are the choices for payment dates for the individual dental plans?

A: The first payment made is for one month of coverage (or 1-year if annual billing) and includes the enrollment fee (if applicable).

- **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 & ortho coverage

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

A: There is no preauthorization requirement for dental. However, in the event dental treatment is expected to be more than $300, the member or their dentist may submit a proposed dental treatment plan prior to their treatment that we will use to estimate if the dental benefits will cover the treatment. This is optional and not required, though we encourage it so the members can understand their financial obligation for any dental services they receive

The dental pretreatment plan may include a(n):

- List of services to be performed, including any supporting documentation, such as ADA codes and descriptions and X-rays showing the dental needs.
- Written description from the dentist of the treatment.
- Itemized list of costs.

The estimate of dental benefits is not a guarantee of what we will pay. It tells the member and dentist in advance about the benefits that may be payable for the covered expenses in the pre-treatment plan.

We recommend having the provider electronically submit the pre-treatment request at least 14 days prior to the scheduled date of service. The pre-treatment plan is valid for 90 days after the date we notify the member and the provider of the benefits payable for the proposed treatment plan.

Q: Is orthodontia covered on any Humana IDV plan?

A: No, there is no orthodontia coverage on any Humana IDV plan. However, members may receive a discount on ortho services when using a Humana in-network provider. For Texas see benefit summaries.

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 submit the claim to Humana if they use an out-of-network provider. 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.

- The dentist information (dentist full name and address) that performed the services, and the dentist's Tax ID number, which can be obtained from the dental office.
- The dentist should provide additional documentation, if required, for any services, including 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?

A: To modify a dental plan (such as changing from Preventive Plus dental to Humana Extend), there are two options:

1. Agent and member can call Humana Customer Service and request plan cancelation. Once Plan is canceled (agent can see this in their Vantage book of business), the Agent can enroll the member for a new plan via Enrollment Hub or other designated enrollment platform.
2. Member calls Humana Customer Service and request plan change or cancelation. Customer Service will send a paper application and indicate "modification of coverage" at the top of the application.

NOTE: Depending on the state, a new enrollment fee may be required for the newly selected plan. Agents can also access a paper application via the **Sales Enablement Library** on Vantage. Refer to the Appendix within the **IDV Agent Plan Grid** for paper applicable form numbers, specific to the plan and state.

Q: How can a member cancel their IDV plan?

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

Note: In the case of Humana's on-exchange dental plans, enrollment and disenrollment can only be completed through the Federally Facilitated or State-Based Health Exchange in which the plan was enrolled either through **www.Healthcare.gov** of the State-Based Health Exchange website (varies by state).

Q: Can a member remove themselves from an IDV plan, but keep their children on the plan?

A: Yes. The member should call Customer Service (phone number on back of ID card) to modify their plan. The youngest dependent child would become the subscriber.

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 & benefits

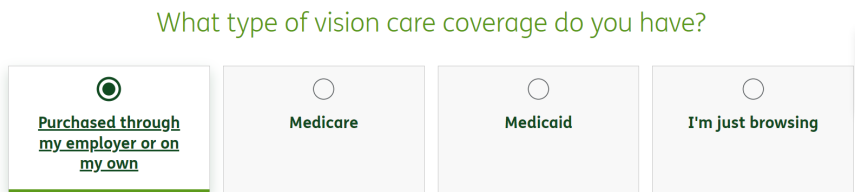
Q: Where agents can find plan information

A: Find out which individual Specialty Plans are in your area with the **IDV 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 & AOA link

Q: Who can enroll in IDV plans?

A. Anyone of any age can enroll in dental, vision and dental, vision, hearing (Humana Extend) plans. Parents and guardians can enroll children in any Humana IDV plan without enrolling themselves (note: parents may have benefits at work, but there may be no family plan offered, necessitating a stand-alone plan for children)

Q: How can prospects enroll in IDV plans after speaking with an Agent?

A. AGENT ONLINE APPLICAION (AOA): Agents can use the AOA link to close business if a member chooses to enroll at a later time. Send the AOA link to prospects; then the individual can self-enroll online, listing the 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.*

Q: Where can agents complete enrollments for individual vision plans?

A: Agents can complete electronic application in Enrollment Hub, found on Vantage:

- When you open Enrollment Hub, 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 select a plan (dental, dental/vision/hearing or vision).
- Continue with Enrollment Hub to complete the application. Alternative for signature are phone signature or text signature.

Plan changes require the use of paper applications. Agents can access paper applications via the **Sales Enablement Library** on Vantage. Refer to the Appendix within the IDV Agent Plan Grid for paper applicable form numbers, specific to the plan and state.

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, for example, if they are permanently disabled.

Q: The member is enrolled on an individual vision and they are moving to a different state. What do they need to do?

A: Members can call Customer Service (phone number on the back of the ID card) and ask for assistance changing to a plan in their new state. Plans and rates are state specific. Members should complete this plan-to-plan change within 30 days of moving.

2.2.E. Vision effective dates and payment dates

Q: How are the effective dates calculated?

A: The effective date can be as soon as five calendar days after the initial payment and application have been received, or as far out as 90 calendar days from date of application.

Q: What are the choices for payment dates for individual vision plans?

A: The first payment made is for one month of coverage (or 1-year if annual billing) and includes the enrollment fee (if applicable).

- **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 show 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.

2.2.F. Vision claims

Q: How are in-network vision claims filed?

A: The in-network providers search within 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 does a member submit 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 up front, 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 IDV plan?

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

Q: Can a member remove themselves from an IDV plan, but keep their children on the plan?

A: Yes. The member should call Customer Service (phone number on the back of ID card) to modify their plan, The youngest dependent child would become the subscriber.

Section 3 - Agent and customer service support

3.1.A Pre and post enrollment assistance

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 Service 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 by following the instructions on this website: **Humana.com/caring-for-others/caregiver-access-to-protected-health-information**.