Individual Dental and Vision FAQs

Includes Medicare OSB/MSB, as well as Stand-Alone Dental and Vision

This Frequently Asked Questions document outlines some questions we commonly receive from agents. There are 2 sections:

→FAQ SECTION 1: Medicare Advantage dental and vision benefits
→FAQ SECTION 2: Stand-alone dental and vision benefits

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."*

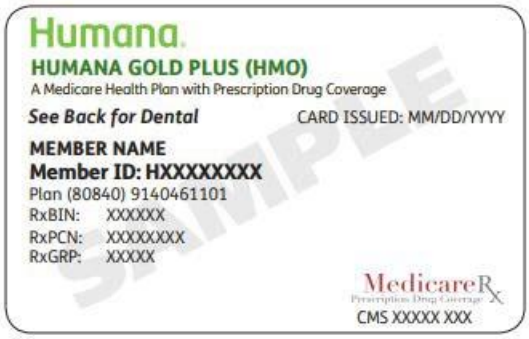
Section 1 – Medicare Advantage Table of Contents (TOC)

Click on the topic to go directly to that section

1.1. 2019 Humana Medicare Advantage Mandatory Supplemental Benefits (MSB) and Optional Supplemental Benefits (OSB) Dental FAQs.

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

The Medicare Advantage ID card includes information about your medical benefits on the front of the ID card, and indicates information about your dental benefits on the back of the card.



The 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.

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 summary of benefits.

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 summary sheets.

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 also 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 reference the Limitations and Exclusions in those documents as well.

1.1.C. Flex allowance (D/V/H)

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

The easiest way to know if a Medicare Advantage plan features a Flex allowance is to check 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. Allowance amounts vary by plan.

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 descriptions.

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 are on the card). (Note: Members on certain co-branded Humana-USAA Honors Plans featuring Flex allowance will receive a USAA Health Flex card instead of the Humana Spending Account 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 balanced on prior year's services.

Here are a few examples:

Example #1: If 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 *The m*ember can then use their Flex allowance to pay toward this remaining out of pocket balance for covered services

Example #2: If the member has a vision allowance of $300, but picks 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 Medicare Advantage 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 (on a Humana plan), Humana wouldn't cover a new upper denture until the 5-year period was up (3 more years in this example). But if the member needed a new denture (one that they 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: Can a member enroll on an OSB at anytime throughout the year?

A. Yes, members can enroll any time through the year with an effective date of the month following their enrollment.

Q: Is there a limit on the number of OSBs a member can enroll in?

A. A member is not able to have multiple of the same type of OSB. Members are able to have a dental OSB, vision OSB, and/or a fitness OSB if their plan offers these options, but not multiple of the same OSB type.

Q: Do OSBs cover out-of-network services on both an HMO and PPO?

A. Yes, OSBs always have both in and out-of-network coverage.

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

A. The OSB is always an enhancement from the MSB.

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 the member buys an OSB, do they lose preventive services that were on their MSB?

A. No, members would not lose preventive by purchasing a dental OSB. The complete list of covered services on the OSB can be found at Humana.com/sb.

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 MAPA; if a member calls customer care (on back of the ID card) , they are routed to a sales agent who can complete their OSB application by phone. It becomes effective the 1st of the following month, in general.

Q: How can a member drop an OSB?

A: To drop an OSB, the member must call customer care 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.

Fax:
800-633-8188

Mail:
Humana
PO 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: Every year there are some MA plans that have a change in the DENxxx plan design available as an OSB for that plan. In that case, the current year version of the OSB will term at year end (12/31/xxxx).
In some cases, an OSB is no longer offered because the embedded dental benefit (MSB) for the new year has benefits that include preventive, basic and major services.
In other cases, an OSB is still offered, but it has a different DENxxx from the prior year. A member must enroll in that new year OSB choice.
The ANOC will provide instructions on what to do in the case of an OSB that will term:

"Not available with your xxxx (new year) plan. If you would like to explore OSB options for xxxx (new year) , please contact your agent at this time or call OSB sales on or after December 8, xxxx at 888-413-7026."

1.1.G. Dental annual maximum of the Medicare Advantage 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 dental

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

A: The 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 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 network mentioned above.
The preferred place to locate in-network providers is in the Humana.com directory.

1.1.I. Out-of-network dental claim

Q: How do we submit an out-of-network 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.

Q: Out-of-Network (OON) Denture Coverage: Many MSB or OSB plans cover Dentures 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: Here is an example of how the 100% coverage of out-of-network benefits display in the Evidence of Coverage:

DENTAL SERVICES
The cost-share indicated below is what you pay for the covered service.

Medicare covered dental	**20%** of the cost	**20%** of the cost
Routine dental DEN133 Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at Humana.com > Find a Doctor > from the Search Type drop down	• **$0** copayment for periodontal exam up to 1 every 3 years. • **$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years. • **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years.	• **$0** copayment for periodontal exam up to 1 every 3 years. • **$0** copayment for complete dentures, partial dentures up to 1 set(s) every 5 years. • **$0** copayment for panoramic film or diagnostic x-rays up to 1 every 5 years.

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 dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefits maximums, limitations, and/or exclusions. You may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider."*

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 actually be periodontal maintenance (D4910).

1.1.K. Alternate benefit

What is an "alternate benefit?" Here is an example of where an alternate benefit is listed. It means that the code is a covered service, but it is paid at the value of a lower service. In this example, the Metallic two-services inlay (D2520) is paid at the level of the onlay- metallic-two services.

Crowns	
D2510	Inlay - metallic - one surface **(alternate benefit only)**
D2520	Inlay - metallic - two surfaces **(alternate benefit only)**
D2530	Inlay - metallic - three or more surfaces **(alternate benefit only)**
D2542	Onlay - metallic - two surfaces
D2543	Onlay - metallic - three surfaces
D2544	Onlay - metallic - four or more surfaces

1.2. MSB and OSB Vision

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 is to use the Humana.com provider directory, and look within the Vision section as indicated in the Summary of Benefits.

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

A: These plans indicate in the summary of benefits that the best way to find the in-network providers is to look in the medical directory of the Medicare Advantage plan.

1.2.B. 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. See a sample of this claim form attached here.

Section 2 – Stand-Alone Dental /Vision Plans Table of Contents (TOC)

Click on the topic to go directly to that section

2.1. Humana Stand-Alone Dental plans

2. Humana Stand-Alone Vision plans

Stand- Alone Dental (such as Complete Dental, etc) and Vision

2.1.A. Finding information about plan benefits

Q: Where agents can find plan information

A: Individual Specialty Agent Grid, found on IgniteWithHumana.com is extremely useful since it allows you to view the individual dental and vision plans available in your state, providing links to the benefit summaries and rate sheets for those plans.

Q: Where members can find plan information

A: Members can find their benefit summaries and certificates of coverage in the secure member portal HumanaOneMembers.com. To register, they will need their member number, which is listed on their ID card, which they will receive through the mail. Agents can also see the member's number in their Vantage book of business. Members can call customer service if they want materials sent to them (customer service phone number is on the back of the ID card). Agents are able to request that Humana send these materials to the member by submitting a Service Inquiry in Vantage.

2.1.B. Dental Provider Directory

Q: Which provider directory should I use?

A: The provider directory to use for individual dental and vision is the one located in Humana.com/DentistFinder. You can search for PPO and HMO providers in that portal.

2.1.C. 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). Additionally, the member must choose a primary care dentist (PCD) as part of the DHMO application. If they do not indicate the PCD, they will not be able to use the plan, since this is an HMO plan, and the member must be on the roster of the chosen provider.

Q: What choices does the applicant have for recurring payment dates?

A: The initial payment must be made at the time of application. Regarding the recurring payment dates, the member may choose one of these dates: the 5th, 15th or 25th. Drafts for recurring payments may be made 2-3 days in advance of these dates. (Note: Members using paper bills will not select a recurring payment date and the payment date will always be the first of the month.)

2.1.D. Missing tooth Clause

Q: How does the missing tooth clause work?

A: Humana's Individual dental plans have a missing tooth clause in the Limitations and Exclusions. 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. Thus, the frequency limitations apply. This is how it is stated in the Humana Extend 5000 certificate of coverage.

"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."

2.1.E. Waiving of waiting periods (Complete Dental, Humana Extend 5000)

The application 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, which a lapse of no more than 63 days (between the time the prior coverage dropped to the effective date of the new plan).
That 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 F. Verification of coverage?

Sales cannot provide verification of benefits. Many services are subject to a clinical review process to determine eligibility for coverage. For verification of coverage, we recommend that the member's dentist send in a pre-treatment estimate to Humana with the specifics of their treatment to receive confirmation of this type of benefit.

2.1 G. Coordination of benefits

Q: Is there coordination of benefits for members who have a stand-alone dental plan from Humana in addition to an MSB Dental with their Medicare Advantage plan?

A: The individual dental plan does coordinate with the Medicare Advantage plan. For these members, the Medicare Advantage dental benefits are primary. The individual dental plan could be used for services that are not covered by the Medicare Advantage plan.

2.1.H. Out-of-Network claims

Q: Will out-of-network providers balance bill?

A: We have some plans that have the same coinsurance for in and out-of-network plans, such as Loyalty Plus. Let's say Humana covers 100% of a cost in and out-of-network.
For in-network providers, assuming that we cover the procedure codes, the member would likely not have any member cost share. However, in the case of out-of-network, there would likely be a balance bill portion that the member would need to pay.

** Out of-network dentists have not agreed to provide services at contracted fees. If a member sees an out-of-network dentist, the coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. Members are responsible for the difference between the INFS and dentists' charged fees when visiting an out-of-network dentist.

If a member is using an out-of-network provider for major services, the member can ask their dentist for a pre-treatment estimate. This will provide clarity to any amounts that the member will be responsible for paying.
Out-of-network dentists may submit claims to Humana on the member's behalf. However, if the dentist will not do that, the member should pay the dentist then submit that receipt together with an out-of-network dental claim, using the American Dental Association claim form. The member should also submit the dentist's detail of services provided. The claim should be submitted to the address on the back of the member's dental ID card.

Q: How to file out-of-network claims for individual dental

However, if you're a Humana member who's enrolled in dental benefits and you need to submit a dental claim for reimbursement, send a copy of the itemized statement from your dentist to the address on the back of your dental ID card. Make sure the itemized statement includes the patient's name and the Humana member's ID number.

Q: How to file out-of-network claims for individual vision.

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. See a sample of this claim form attached here.

2.1.I. Changing a plan or cancelling a plan

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

A: In order 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. Also, the member will maintain the same member number, and 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 Dental and Vision Agent Plan Grid for paper applicable form numbers, specific to the plan and state."

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

A: The member is only required to call Dental Customer Service (phone number on back of ID card) to cancel the policy. The Customer Service Representative health will then send an email to our Billing/Enrollment department, explaining the reason for cancellation. Agents can also request this through a Vantage service inquiry. Note: Members may have a minimum 1-year contract on their plan.

Q: How can a member cancel their individual off exchange 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.

Q: How can a member change or cancel their Smart Choice on-exchange dental plans.

A: Enrollment for these plans is handled by Healthcare.gov.

2.1.J. Child Only applications

Q: If two children are enrolled into a dental or vision plan without an adult being enrolled who is primary?

A: The youngest is the primary.

2.2 Individual Vision plans

2.2.A. Finding plan information

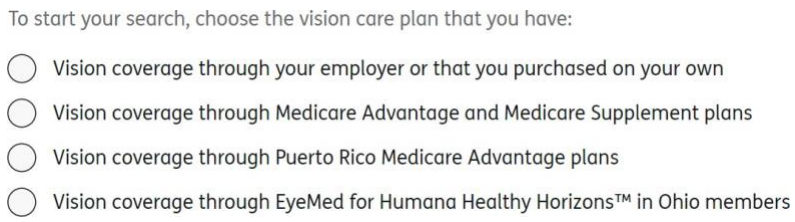
Q: How can members find information about their vision plan's benefits?

A: Members can find their benefit summaries and certificates of coverage in the secure member portal HumanaOneMembers.com. To register, they will need their member number, which is listed on their ID card, which they will receive through the mail. Agents can also see the member's number in their Vantage book of business. Members can call customer service if they want materials sent to them (customer service phone number is on the back of the ID card). Agents are able to request that Humana send these materials to the member by submitting a Service Inquiry in Vantage.

2.2.B. Vision Provider Directory

Q. Which provider directory should I use?

A. The provider directory to use for individual vision is the one located in Humana.com.
First, you will indicate "purchased on your own" which indicates individual vision plans.



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