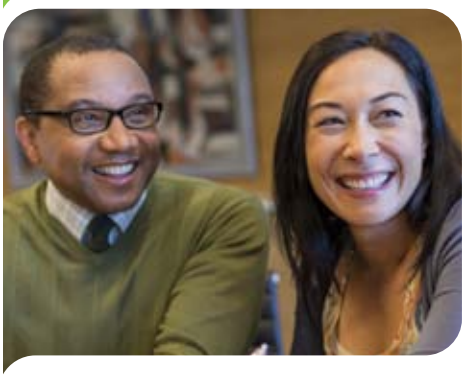
Frequently Asked Questions for Individual Dental and Vision



Pre-sale or process questions:
Agent service center

1-800-833-2572

E-mail: agentask@Humana.com

Post-sale Agent Customer Care:
1-888-692-2669

1. **Where can we go for an online provider finder for dental and vision?**
   a. The website www.HumanaOneNetwork.com is available to both agents and members. This site offers printable and downloadable results so you can share the network information with members that might not have internet access. To see providers, simply enter the zip code and the plan name that you are searching for and hit "Find Providers". Once the results appear, you will be able to select the "Print Results" option under the "Find Providers" button.

2. **How are effective dates determined for the standalone dental and vision products?**
   a. Effective dates are determined based on when the application is received for processing. If you are mailing the application, please allow mailing time.
   b. We do not backdate applications. Effective dates must be in the future.
   c. DHMO (Dental C550) effective dates are calculated as follows:
      i. If application is received between the 1st and 15th of the month, the policy effective date will be the 1st of the following month.
         1. Example: Application received on May 10 will have an effective date of June 1.
      ii. If application is received between the 16th and end of the month, the policy effective date will be the 1st of the 2nd following month (the month after the following month).
         1. Example: Application received May 18 for processing will have a policy effective date of July 1.
      iii. The reason for the difference in effective dates is due to the member having to select a primary care dentist and being included in the monthly membership rosters sent to providers.
   d. Dental Preventive Plus, Loyalty Plus, Vision Care Plan, Vision Focus Plan effective dates are calculated as follows:
      i. Regardless of when an application is received for these plans, the policy will have an effective date of the 1st of the following month.
         1. Example: Application received on May 10 will have an effective date of June 1.
         2. Example: Application received on May 31 will have an effective date of June 1.

3. **How do I sell these plans?**
   a. These plans can be sold via paper applications (available on Agent Work Bench) or online through Agent Work Bench.

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4. Can members terminate their coverage?

a. There is a one year contract with these plans, please make sure to explain this requirement to applicants.

b. Dental C550 members can terminate their coverage within the first 30 days of their effective date, but they will only be refunded their premium (not enrollment fee) and will be responsible for any claims incurred during this time. After the 30 day window, cancellations are not accepted unless for approved exceptions.

c. Dental Preventive Plus, Loyalty Plus, Vision Care Plan and Vision Focus Plan members can terminate their coverage within the first 10 days of their effective date, but they will only be refunded their premium (not enrollment fee) and will be responsible for any claims incurred during this time. After the 10 day window, cancellations are not accepted unless for approved exceptions.

5. Do these plans have a "30 day free look window"?

a. The Dental Preventive Plus, Loyalty Plus, Vision Care Plan and Vision Focus Plan all have a 10-day cancellation window from the effective date, but we should not market this as "free" because even if the plan is cancelled within this window, the member will only receive a refund of premium, but the enrollment fee is non-refundable. The member will also be responsible for paying the full cost of any services received during this time period.

b. We should not be marketing these cancellation windows and should instead be explaining that these plans carry a one-year contract.

6. Do these plans automatically renew every year or must the member re-enroll?

a. These plans automatically renew after the one year contract. Annual paper bill payors will get an invoice prior to the renewal. Monthly paper bill payors will continue to get monthly paper bills. All paper bill payors will continue to get invoices from us until they opt-in to paying through credit card or automatic bank withdrawal.

b. Members paying through all other methods will auto-renew and will pay all future payments with the payment method on file. Members will only be dropped for non-payment.

7. What happens if a member does not pay his/her premium?

a. If the member pays by monthly bank draft or credit card, his/her plan will be cancelled the first time payment is not received by the due date. If paying annually, we will terminate the plan for non-payment after 30 days following the renewal date.

b. Recurring credit card and bank draft payments occur on the 15th of the month. The due date for monthly paper bills is the 15th of the month.

c. If a member lapses and would like to reinstate, they must call within 60 days of their lapse date and pay missed premiums to be reinstated without paying the enrollment fees again. If they call to reinstate outside of this 60-day window, they will need to pay the enrollment fee again and the waiting periods (for the Preventive Plus plan) will start over.

8. How are the fees for these plans charged?

a. If the member is paying monthly, the first payment (taken at the time of application) will include the one-time, non-refundable enrollment fee, the $1 administration fee, monthly premium, and $0.75 association fee (if applicable to their state/ product). Future months' payments just include the monthly administration fee, monthly premium, and monthly association fee (if applicable).

b. If a member is paying annually, the first year's payment (taken at the time of application) will include the one-time, non-refundable enrollment fee, yearly premium, and $9 association fee (if applicable to their state/product). The administration fee is waived for annual payors. Future years' payments will just include the yearly premium and $9 association fee (if applicable).

c. If a member is purchasing a dental and a vision plan, the enrollment fee must be paid for each plan.

All administration and association fees will also be paid per plan.

9. How are fees charged if a member is purchasing both a dental and vision plan?

a. Currently, all fees are charged per plan. If a consumer buys a dental and a vision plan, the one-time, non-refundable enrollment fee(s) will be charged in the first payment for each plan, the $1 administration fee will be charged each month per plan (this is waived if paying annually), and the association fee* will be charged each month per plan (for annual payors, this will be a $9 fee with their payment).

* Only applies to association products and states. To see which states have an association fee, please login to Agent Workbench and click on "Product Availability" under "Stand-alone Dental and Vision".

10. If a member cancels his/her plan and re-enrolls later, do they have to pay a new enrollment fee?

a. Yes.

11. How are these plans billed?

a. The first payment is taken immediately upon receipt of the application, not when the plan becomes effective. There are no exceptions to this rule. Please make sure to explain this rule to applicants and ensure they have the funds ready and are aware they will be paying immediately.

b. These plans automatically renew after the one year contract. Annual paper bill payors will get an invoice prior to the renewal. Monthly paper bill payors will continue to get monthly paper bills. All paper bill payors will continue to get invoices from us until they opt-in to paying through credit card or automatic bank withdrawal. If paying through automatic bank withdrawal or credit card, all future payments will be automatically drafted/ charged.

c. Recurring credit card and bank draft payments occur on the 15th of the month. The due date for monthly paper bills is the 15th of the month.

12. What are the payment options for these plans?

a. Through Agent Workbench these plans can be sold with monthly, semi-annually, quarterly, or annual payment options. Payment types include monthly and annual bank draft, monthly and annual credit card payments, and annual bills.

b. Through paper these plans can be sold monthly and annually. Payment options include monthly and annual bank draft, monthly and annual credit card payments, and monthly and annual bills. The monthly bill option is not preferred and should only be offered if the prospect is unable or unwilling to pay electronically. Please attempt to overcome objections to electronic payment as the paper bill option is more costly and increases the risk of non-payment.

c. We accept both Visa and Mastercard payments.

13. When do members receive their ID cards and how do providers recognize active members?

a. Members should receive their ID cards 1-2 weeks after their application is received and enrollment is processed, and should bring their ID cards with them when visiting the dentist. Members should inform their provider of their plan when scheduling their appointment to avoid any issues at the time of service.

14. What is sent to the member upon enrollment?

a. Members will receive a welcome packet that includes a welcome letter with their ID card attached and a benefit summary for the product purchased. The ID card contains the member's ID, plan name, network, customer care phone number, and claims address. A provider directory is not included in this packet. Members that purchased an association plan will also receive a website address and login information for the People's Benefit Alliance.

15. Who should I contact if I have questions?

a. Agent services for pre-sale questions: 1-800-833-2572.

b. Agent services for post-enrollment questions: 1-888-692-2669.

c. VCP Customer Service number: 1-800-865-3676.

d. EyeMed Customer Service number: 1-877-480-5669.

16. Who should I contact if there is a claims issue?

For dental claims, call Customer Care at 1-800-342-5209.

For vision claims issues, call Customer Care at 1-800-865-3676.

17. Who is responsible for processing grievances?

a. Please direct grievances to: HumanaOne, PO Box 14729, Lexington, KY 40512-4729. All grievances should include the customer's name and policy number.

18. In the benefit grids, some procedures reference a percentage discount. How do the discounts apply for the dental plans?

a. With the Preventive Plus plan, major services are not a covered benefit. Members may receive discounts on major services like root canals, crowns, and other services when they choose one of the more than 170,000 dentist locations in the network. Members can find dentists in the network by visiting www.HumanaOneNetwork.com.**

b. With the Loyalty Plus plan, orthodontics are not a covered benefit. Members may receive discounts on these services when they choose one of the more than 170,000 dentist locations in the network. Members can find dentists in the network by visiting www.HumanaOneNetwork.com.**

c. With the Dental C550 plan, the copays on the benefit grids only apply to services received at a general dentist. For any services not listed or for those performed by a participating specialist (ex: root canal performed by an endodontist), the customer may receive a 25% discount from the provider's usual and customary fee.**

d. We recommend that our members take their benefit grids and a copy of their ID cards with them to the dentist so they can estimate what they may pay for their procedures.

19. Can a dental member who enrolls in one state access the dental network in another state?

a. Dental C550 members can only enroll in plans that are offered in the state in which they reside (or where they file taxes). For example, if a member is in Florida part-time, but is a full-time resident of Georgia, they must purchase the plan and can only receive services in Georgia. The only exception to this would be for emergency treatment while out of their resident state. Emergency services are covered in or out of network.

b. Dental Preventive Plus, Loyalty Plus, or Vision Plan purchasers are allowed coverage at any network provider throughout the country (even in states where we do not sell these plans). Example: If you live in Tennessee and have our Preventive Plus plan but are traveling to another state, the Tennessee benefits follow you no matter where you travel, regardless of where you receive services.

20. Do the dental plans have out-of-country benefits?

a. The Dental C550 plan does not offer out-of-country coverage.

b. Dental Preventive Plus and Loyalty Plus members can see a foreign dentist, and if the service is covered by the plan, the out-of-network benefits will be applied. The dentist does not need to have an American license. When the member submits the claim, please make sure they:

- Attach receipts translated to English.
- Include X-rays (if the procedure required).
- Include the American ADA code or an English description of the service provided.

21. Can a member get unlimited X-rays and oral exams with the dental plans?

a. The Dental C550 plan does not limit these benefits, but please note additional copayments or fees may apply as providers reserve the right to determine if such benefits are necessary. Please review the limitations and exclusions as well as benefit summaries and certificates for specific details.

b. The Preventive Plus and Loyalty Plus Plans limit cleanings to 2 per calendar year and bitewing X-rays are limited to 1 set of 2 or 4 per calendar year. Miscellaneous X-rays (taken for diagnostic purposes) are limited to 1 per calendar year. The Loyalty Plus plan also covers full mouth/panorex X-rays 1 per 5 years and share the same frequency. Please review the limitations and exclusions as well as benefit summaries and certificates for specific details.

22. Can a member purchase both the DHMO C550 and Preventive Plus?

a. No, our plans do not coordinate benefits with each other and should not be sold in conjunction.

23. Can our dental plans supplement other dental plans?

a. No, our plans do not coordinate benefits with other dental and vision plans and should not be sold to supplement other dental or vision insurance.

24. What is the process for selecting a dentist for the Dental C550 plan?

a. The Dental C550 plan requires a dentist selection, so before an application can be submitted, a dentist must be indicated on the application. Please use HumanaOneNetwork.com to view all available dentists. Once the results appear for the indicated zip code, please discuss the options with the customer and let them select their dentist. This selection may be changed, but there may be a delay on any updates, so please make sure the member is comfortable with their initial selection.

25. What are some selling features of the Dental Preventive Plus plan?

a. Unless the six-month waiting period on basic services (which primarily applies to fillings, surgical extractions and oral surgery) is an absolute deal breaker, the following factors make the PPO an appealing option for the consumer:

- Far more extensive network in all markets than the C550.
- Ability to see a specialist without referral and receive care, if needed, when traveling.
- Customers who indicate a preference for staying with a dentist who is not in the PPO network can still receive some benefits for preventive care on an out-of-network basis. We can still sell them on in-network care should they need to see a specialist, and encourage them to use a participating provider for those services. Just because their general dentist is non-participating, doesn't mean they can't see a participating dentist for other services.
- Texas, Georgia and Louisiana have the same in and out-of-network coinsurance.
- Tennessee does not have the waiting period for basic services.
- For the Dental C550 plan, any services not listed or for those performed by a participating specialist, the customer may receive a 25% from the provider's usual and customary fee.**
- For the latter half of the month, the PPO has an earlier effective date available than the C550 (you can enroll for the 1st of the next month coverage right up through the last day of the month).

26. What are some selling features of the Dental Loyalty Plus Plan?

a. The dental plan rewards members for loyalty by increasing benefits from years one to three, with increasing coverage on services like routine exams, root canals, and crowns.

b. This plan has a one-time deductible for as long as you are on the plan.

c. There are no copays or waiting periods.

d. Ability to go to the dentist you prefer with the comfort of knowing this plan pays the same percentage of the cost no matter which dentist you visit.

27. How do I overcome objections to the six-month basic services waiting period for the Preventive Plus plan?

a. Emphasize the importance of seeing a dentist to get an accurate evaluation of the procedures that are needed. Many callers think they need extractions or fillings (both of which have the services waiting period) but, after seeing a dentist, the member may learn they do not need these procedures after all. The routine evaluation, cleaning, and X-rays are paid 100% in network on the first day of coverage.

b. Just because we have a basic services waiting period does not mean that the member has to wait before getting the procedure done. They can choose to get work done before the waiting period is up, as waiting period services may still be eligible for a discount, they will just pay for it out-of-pocket.** With the amount they will be saving on the initial exam though, it is still worth purchasing the insurance.

c. In Tennessee there is no waiting period for Basic Services.

28. How is the annual maximum calculated for the Dental Preventive Plus plan?

a. Annual maximums are calculated per member per calendar year. Each calendar year, the annual maximum resets. All covered services where the plan makes payment apply toward the annual maximum (i.e. preventive/basic services). Member payments do not apply toward the annual maximum. Both in-network and out-of-network services count toward the annual maximum. Discount services, if they are available, are not subject to the deductible.**

29. How is the annual maximum calculated for the Dental Loyalty Plus plan?

a. Loyalty Plus plans have increased maximum amounts the plan will pay annually: $1,000 in year one, $1,250 in year two, and $1,500 in year three and after.

b. Annual maximums are calculated per member per plan year. Each plan year, the annual maximum resets. All covered services where the plan makes payment apply toward the annual maximum (i.e. preventive/basic/major services). Member payments do not apply toward the annual maximum. Both in-network and out-of-network services count toward the annual maximum. Discount services, if they are available, are not subject to the deductible.**

30. How is the deductible applied for the Dental Preventive Plus plan?

a. For Preventive services, the deductible is waived if seeing an in-network dentist (*Please note, some states also require the deductible to be waived on out-of-network services as well). If seeing an out-of-network dentist, the deductible must be paid prior to the plan covering preventive services. After the deductible is met, the plan pays its portion of coinsurance (varies by state) for preventive services.

b. Basic services are subject to the deductible, regardless of whether the member is seeing an in-network or out-of-network dentist. Once the deductible is met, the plan will pay its portion of coinsurance (varies by state).

c. Discount services, if they are available, are not subject to the deductible.**

d. Each plan member has a deductible once per calendar year, and then it does not need to be met by them for the remainder of the year. A family does not need to meet more than 3 deductibles in a calendar year. Once the third family member meets his/her deductible, we will waive the remaining family members' deductibles for the rest of that calendar year.

31. How is the deductible applied for the Dental Loyalty Plus plan?

a. For Preventive services, the deductible is waived if seeing and in-network or out-of-network dentist.

b. Basic and Major services are subject to the deductible, regardless of whether the member is seeing and in-network or out-of-network dentist. Once the deductible is met, the plan will pay its portion of coinsurance.

c. Discount services, if they are available, are not subject to the deductible.**

d. One-time deductible for as long as you stay on the plan: $150 per person, up to $450 for a family.

32. With the Vision Focus and Vision Care plans, can I get both contacts and lenses?

a. Members can only utilize the eyeglass lens benefit OR the contact lens benefit, not both. If members choose, they may elect either benefit in the first 12 months of coverage, and in the next 12 months use the opposite benefit.

33. With the Vision Care plan, how are costs handled for frame selections that exceed the $40 in-network wholesale allowance?

a. If a member chooses frames with a wholesale cost over $40, the member would be responsible for 2x the amount over the $40 wholesale price. Example: Wholesale price is $75, but wholesale allowance under plan is $40. Member pays 2x the difference or $70 ($75 - $40 = $35 x 2 = $70).

Please note that this determines the cost of the frames only. Lenses carry a $25 copayment for basic lens, however other lens types and options (tinting, polished edges, etc.) are available at a discounted rate.

**Not applicable in the state of Georgia.