Humana Dental Highlights

A publication of Humana Dental

Quarter 4 2025

Autumn shows us how beautiful it is to let things go – Unknown

Humana recognizes the exceptional service given to our members by our participating dentists and the critical role this plays in preserving our members' oral health. Humana is committed to our providers to share relevant information for their dental practice, updates on plan offerings and other dental-related news.

Important plan information

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Important plan information

Medicare Advantage benefit updates for 2026

Dental coverage on 100% of Medicare Advantage plans

- All Humana Medicare Advantage (MA) plans will cover 2 cleanings a year, plus exams and X-rays on 100% of MA plans nationwide.
    - Dental benefits for 2026 are available for review at Humana.com/sb. Providers are encouraged to visit the site to access the latest plans and coverage details.

Major services and periodontal scaling coverage

- 83% of patients will have embedded benefits that cover some major services.*
- 86% of patients will have plans that cover periodontal maintenance.

Please note: Some integrated Dual Special Needs Plans (DSNP) in Illinois, Indiana and Michigan include dental benefits that do not utilize the HumanaDental Medicare Network, specifically: DEN197, DEN198 and DENH54. For more information, please visit www.dentaquest.com/en/providers.

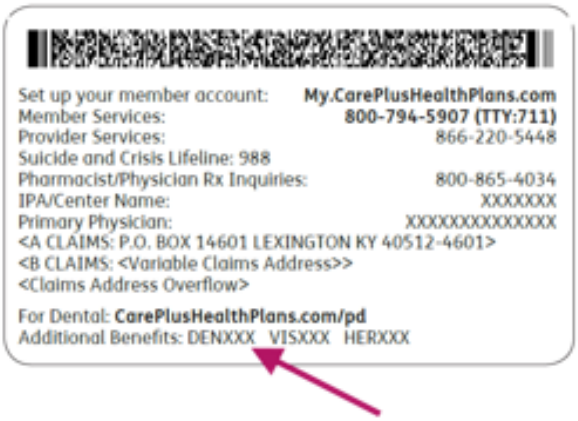
*Low coinsurance may apply to select major services depending on the patient's MA plan.

Important CarePlus MA member ID card changes for 2026

As we approach the 2026 plan year, we wanted to alert all CarePlus Health Plans providers to some significant changes with the CarePlus MA member ID cards. All CarePlus member ID cards will begin with the letter H as of Jan. 1, 2026. Additionally, all CarePlus MA members will receive a single member ID card containing the medical benefit on the front of the card and the dental benefit information on the back of the card for 2026. A separate dental ID card will no longer be issued. A summary of these changes as well as a sample ID card can be found below.

CarePlus MA member ID card changes for 2026

- All CarePlus MA member IDs will begin with the letter H as of Jan. 1, 2026.
    - For dates of service before and on Dec. 31, 2025, please bill your CarePlus-covered patient's current member ID. 2025 CarePlus MA member IDs begin with a number.
    - For dates of service on and after Jan. 1, 2026, please bill your CarePlus-covered patient's new member ID that begins with the letter H. If you bill using the legacy member ID that begins with a number, our system will be set up to crosswalk the legacy member ID with the new member ID, but it may delay your remittance and may make reconciliation difficult.
- Effective Jan. 1, 2026, CarePlus MA members will not receive a separate dental ID card. Beginning on Jan. 1, 2026, CarePlus MA members will use a single member ID card with the medical benefit on the front and dental benefit on the back. 2026 member ID cards are mailed starting Nov. 1, 2025.
    - The patient's dental plan number will be located on the back of their CarePlus member ID card and indicated with DENxxx. See the member ID card image below for reference (specific DEN number varies by plan).



FEDVIP plan information

For details on how to administer Humana Federal Employees Dental and Vision Insurance Program (FEDVIP) plan benefits, including schedule of benefits, copay tables, first payer guidelines and more, visit our benefit resource page.

Oral cancer evaluations

The American Dental Association's (ADA) CDT codes below include an oral cancer evaluation as per the ADA's codes' descriptors:

- *D0120 Periodic oral evaluation – established patient*
- *D0150 Comprehensive oral evaluation – new or established patient* and
- *D0180 Comprehensive periodontal evaluation – new or established patient*

Oral cancer evaluations are crucial to detect cancerous growths in early, more treatable stages. According to the American Cancer Society, the overall lifetime risk of developing oral cavity and oropharyngeal cancer is about 1 in 59 for men and 1 in 139 for women.[1] An expert panel of the ADA's Council on Scientific Affairs and the Center for Evidence-Based Dentistry concluded it is good practice for clinicians to perform an intraoral and extraoral conventional visual and tactile examination in all adult patients to screen for oral cancer.[2] As a reminder, Humana's plans include routine oral cancer evaluations at comprehensive and periodic dental visits to ensure our members receive the recommended standard of care.

Antibiotic stewardship and prescribing practices

Humana is reminding providers of the importance of responsible antibiotic prescribing practices. Worldwide, dentists account for approximately 10% of antibiotic prescriptions, and studies have shown many of these antibiotic prescriptions were likely unnecessary.[3] The Centers for Disease Control and Prevention (CDC) estimates at least 30% of outpatient antibiotic prescriptions in the United States are unnecessary.[4] Overuse of antibiotics may lead to issues including antibiotic resistance (meaning that certain microbes may not respond to routine treatment efforts, potentially leading to additional treatment modalities), increased costs, and increased morbidity and mortality.[3,4]

Antibiotic resistance is recognized as a significant threat to public health and is expected to be responsible for 10 million deaths annually by 2050.[3] Observing responsible antibiotic prescribing practices can reduce the number of unnecessary prescriptions, minimizing the harm to individual patients and the community as a whole.[4] Antibiotics should only be prescribed when needed and with the correct antibiotic, dosage and duration in accordance with evidence-based guidelines.[5]

References

1. Oral Cavity & Oropharyngeal Cancer Key Statistics 2021 | American Cancer Society
2. Evidence-based clinical practice guideline for the evaluation of potentially malignant disorders in the oral cavity - The Journal of the American Dental Association
3. Preventing AMR and Infections | FDI World Dental Federation
4. Core Elements of Outpatient Antibiotic Stewardship | Antibiotic Prescribing and Use | CDC
5. Antibiotic Stewardship | American Dental Association

Group DHMO plans introduced in 2024

Humana Dental is pleased to introduce new DHMO plans on the existing HD/HS series in Florida, Georgia, Illinois, Indiana, Kentucky, Missouri, Tennessee and Texas.

- The HD/HS series now includes **HD405, HD410, HD415, HS405, HS410 and HS415**. These plans help maintain and increase patient flow and continue to position Humana Dental as a leader in the dental benefits industry. New group membership on Humana Dental HD/HS plans began April 1, 2024.
- Please refer to your eligibility lists to ensure appropriate benefits are administered to Humana-covered patients during the transition.
- The Schedule of Benefits for these plans with member copayment are available at Humana Specialty dental and vision benefit forms.

Please refer to the member copayment list prior to seeing patients on these plans. Prior to providing any dental services, please remember to verify the member is on your roster.

Group Dental PPO plans coming for West Virginia

Beginning Dec. 1, 2025, Humana Dental is pleased to announce group dental plans launching in West Virginia. A comprehensive dental portfolio will include Traditional Preferred, PPO and Preventive Plus plan options. Prospective members can visit https://www.humana.com/dental-insurance to learn more about plan details and eligibility.

Creating efficiencies for your office

Benefits of using the most current ADA claim form

The ADA introduced an updated Dental Claim Form in 2024, which is designed to be more user friendly and streamline the process for submission and processing of dental claims. While Humana continues to accept any claim form, utilizing the most current form ensures efficient processing of your dental claims. Submitting outdated forms can potentially delay the process and how quickly you receive payment. The new form has enhanced data fields for electronic submission to facilitate faster claim processing.

Access your PPO fee schedule

Did you know you can request your Humana preferred provider organization (PPO) fee schedule anytime—day or night—through Humana's interactive voice response (IVR) platform? It is easy to request a copy of your fees, which Humana will fax to you by following the steps below.

DHMO and Exclusive Provider Organization (EPO) fees are not available through IVR. Dental providers who participate with Humana Dental through a rental network agreement will need to contact the rental network for a copy of their fee schedule.

To request your Humana PPO fees:

1. Call Humana's provider call center at 800-833-2223, Monday – Friday, 8 a.m. – 8 p.m., Eastern time, and say "fee schedule" when prompted.
2. You will be asked to enter your Tax Identification Number (TIN) and the provider's National Provider Identifier (NPI) for validation.
3. You will be asked to enter your fax number. Once the information is entered, your existing PPO fees will be faxed to you.

PPO refers to Preferred Provider Organization health plan; EPO refers to Exclusive Provider Organization health plan; DHMO refers to Dental Health Maintenance Organization.

CAQH ProView can streamline credentialing and recredentialing

Humana understands how busy dental offices are, and we want to help you simplify the credentialing and recredentialing process by sharing how to use **CAQH ProView**, the complimentary system Humana Dental uses to manage credentialing and recredentialing of our network providers. By submitting and maintaining your dentist's professional information in one central place, it eliminates duplication, information is only shared with the organizations you choose and it is free.

You can submit your provider credentialing and recredentialing details in a single source for all healthcare organizations you partner with. Visit our Dental Provider Video Library and select the video **Simplify Credentialing with CAQH ProView.** You can find more helpful information about our credentialing process by visiting the join our dental provider network webpage.

Availity Essentials – tips for using the provider portal

Important: Providers have several options to obtain member eligibility and claim information. If you experience issues with Availity Essentials, you have other options so that patient care is not interrupted:

- Humana's automated phone system can provide 24-hour access to Humana member benefit and claims information and more at 800-833-2223, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.
- Humana Customer Care cannot advise how to use or navigate to www.availity.com, but Availity Client Services (ACS) is available at 800-AVAILITY (282-4548), Monday – Friday, 8 a.m. – 8 p.m., Eastern time (excluding holidays), to assist with registration or navigation questions.
- Registered users can access the ACS Contact Support page to send an online message and create a ticket with the Availity Support team. Select Help & Training> Availity Support> Contact Support. If representatives are available to chat online, the "Start Chat" option will be blue.

Searching Humana Dental transactions

To be sure you receive accurate Humana Dental (or CompBenefits) member benefits, please select Humana Dental in the payer drop-down list. Humana is the medical payer and, if selected, you may see a message that the member is not found. While dental care is a benefit option within medical, this relates only to oral surgery benefits.

Members with multiple coverages

It is important to receive accurate member benefit information, even when the member may not tell you they have additional coverage. When a member has multiple active dental plans, a message may appear indicating the selected patient has multiple plans and you need to select one from the drop-down list to continue. As a best practice, the plan group number should be included when submitting the inquiry. When a member has dual coverage and the group number is not included, it can result in display issues on the benefit results page:

- When a member has multiple active plans under different ID numbers and the group number is not included, a display issue can result where both plans display, but there is a mismatch of the group number on the second plan returned.
- For a member who is a subscriber on one plan and a dependent on another plan, regardless of which ID number is entered, the results will only display plan details for one of the plans and no drop-down list will appear.
    - This is important for providers who use their own practice management systems to view member eligibility and benefits information, as not including the Group ID can cause only one of the member's plans to be seen, regardless of which ID is used.

To ensure Eligibility & Benefit (E&B) results are accurate, it is important to change from the default search option under Patient Information to the fourth option that includes the group number:

- Proceed to the E&B Inquiry page, select your organization and payer (Humana Dental) and fill in the provider Information.
    - Proceed to the Patient Information section of the form. The default search option is Patient ID, Date of Birth. In the drop-down list, select the option for **Patient ID, Date of Birth and Group Number**.
    - This results in a new 'Group Number' field displaying where the group number is entered.
- Continue filling out the remaining required fields on the form and submit. As a result, the accurate benefit information returns for the member ID and group number combination.

MA member IDs and claim status

To verify eligibility for a MA member, you should enter the ID number, also known as the "H" number, from the MA ID card on the E&B Inquiry page. Visit Humana MA Dental Benefits for Providers for more details about Medicare dental benefits and a sample image of a MA ID card.

It is important to note this MA ID number will not work when searching for claim status results because the dental ID must be used. However, after entering the MA ID number on an E&B Inquiry, you will notice on the dental eligibility results page that the dental-specific ID number is provided. This is the ID number specific to dental that can be used in a claim status search under the Claims & Payments menu.

Humana's proprietary Remittance Inquiry tool has been retired

Effective Sept. 20, 2025, Remittance Inquiry (Humana) has been fully retired. The previous landing page has been removed for a streamlined experience. Selecting Remittance Viewer from the Claims

& Payments navigation now takes you directly to the viewer.

Watch a brief demo video to learn more about how to use the Remittance Viewer. Select the link to Watch a demo from the top right section of the Remittance Viewer page. Please utilize the Give Feedback button if you have any comments or concerns to share.

Submit dental claims on Availity Essentials

Registered users can submit claims to Humana Dental via the Dental Claim tool. Please note that options for submitting predeterminations or adding attachments on dental claims are not yet available.

If you do not see the Dental Claim option, check with your Availity administrator to ensure you have the "Claim" role assigned to your profile. If you don't know who your administrator is, select your account name, then select My Account and Organizations from the left menu. From there, select Open My Administrators (next to Administrator Information).

The dental claim form is accessed by selecting the Claims & Payments menu. Under the Claims header, select Dental Claim, choose your organization, select dental claim under claim type, choose Humana Dental as the payer and select the Responsibility Sequence (Primary is the default).

- Complete the fields in order from top to bottom. You have the option to print the claim entry before submitting. Once submitted, you can review and save the claim confirmation page if needed.
- Diagnosis codes are optional and generally used for medical claims. However, a diagnosis code may be required for treatment performed by an oral surgeon or if services were rendered because of an accident.
- "Remarks" is a field used only for information not captured within the existing fields on the ADA form. It is not a place to indicate a corrected claim. Corrected claims can be indicated by selecting the Replacement of Prior Claim within Ancillary Claim/Treatment Information option.

Need help with registration? Visit our page dedicated to Humana Dental providers to learn How Availity Essentials supports your practice. Availity Client Services can be reached at 800-AVAILITY (282-4548) for questions on registration or other portal functionality. You can find Availity-led training sessions with insider tips for using the dental claim tool and other topics in Availity's Learning Center (ALC). You must be a registered user on www.availity.com; select Help & Training | Get Trained for access to the most up-to-date instructions.

Availity Essentials is a free multi-payer portal where you can use **1 user ID and password** to work with Humana Dental and other payers in your state. There is no cost to register and Availity is compliant with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Administrators are responsible for setting up organization accounts and assigning roles to users in their office(s). To work with Humana Dental on Availity Essentials, your organization must have an Availity account.

Compliance corner

Importance of notifying Humana about changes

Humana strives to have the most current provider information so our members can find your practice. You play a key role in helping us maintain an accurate directory. Please notify Humana in a timely manner when updates are needed to your practice information. Remember to include all relevant data for efficient processing:

- Change in location (adding, closing or changing offices)
- Updates to phone number, email and/or web address (if available)
- Changes to your practice's TIN or ownership changes
- Changes to a treating provider's license or NPI, name, specialty, board certifications, languages spoken (if applicable), etc.
- Whether the provider and/or office is accepting new patients
- Office handicap accessibility and office hours information

Keeping Humana informed of any changes to your office or provider information helps ensure our directory remains accurate so members can quickly find in-network dental care. State legislation trends increasingly require prompt and accurate directory information, highlighting the importance of timely updates. Humana may also reach out to your office if we haven't received recent claims from you to ensure we have the most up-to-date information. There are several ways to send us your information:

Sign in to your Availity Essentials account at www.availity.com and:

- Select Humana Dental from the Payer Spaces top menu, then choose the **Dental Provider Directory** application.
  - Select your organization and TIN from the drop-down lists
  - Enter the provider name
  - In the box labeled Current Directory Data, tell us the directory listing that needs updating
  - Finally, in the box labeled Correct Directory Data, indicate the correct information
- On Humana's https://findcare.humana.com/ locate your dental provider's listing:
  - Select the link to **Report incorrect information**
  - An online form opens where you can specify the items that need correction
  - Select "Submit" to send us the feedback

- Participating providers can email their dental Single Point of Contact (SPOC) directly or contact the dental service team directly at dentalservice@humana.com
- If mailing by U.S. Postal Service is preferred, the mailing address is

  Humana c/o Dental Service
  1100 Employers Blvd.
  Green Bay, WI 54344

Utilizing the KX modifier on claims for dental services

Effective July 1, 2025, providers are required to include the KX modifier along with a diagnosis code on a claim when they believe the dental service is medically necessary and include appropriate documentation to support/ justify the medical necessity of the service; coordination of care between medical and dental practitioners must occur.

Humana recommends submitting dental procedures (coverable under the basic medical benefit) as a

predetermination for Medicare HMO or PPO plans or an Advance Coverage Determination (ACD) for Medicare private fee-for-service plans. Important: claims submitted with the KX modifier, but no ICD code will result in a denial. The ICD code is required when the KX modifier is noted on the dental claim and required to be able to route the claim to the medical plan for consideration.

Refer to the **Medicare Basic Dental Benefit Exceptions Guidelines** for more details including page 34 regarding the submission of an ACD/predetermination for dental services inextricably linked to a covered medical procedure or condition. Note: **Claims for Humana MA patients** – please find the claims address and general claims and payment information, including the appropriate claim forms on page 35.

- The Centers for Medicare & Medicaid Services (CMS) implemented guidance in July 2024 regarding submission of claims for dental services inextricably linked to a covered medical procedure or condition. Payment under Medicare Parts A and B may be made for dental services that are inextricably linked to, substantially related and integral to the clinical success of, a certain covered medical service.
- The KX modifier for dental services indicates that the service is "medically necessary" and "inextricably linked" to a covered medical procedure, requiring documentation to prove this linkage. To use it, dentists must coordinate care with the patient's physician, submit supporting documentation to demonstrate medical necessity and include a valid ICD-10 diagnosis code on the claim form.
- CMS provided examples where dental and medical services are inextricably linked and codified such examples under subsection (§) 411.15(i)(3) [see (i) Dental services- and (3) Inapplicability]. These are examples of circumstances where CMS believes there is a clear inextricable link between the dental and medical services, but it is not an exhaustive list of instances where dental and medical services are inextricably linked.

New CMS rule requirement for Medicare predeterminations begins Jan. 1, 2026

Effective Jan. 1, 2026, a federal rule will require all Medicare predeterminations to be completed within 7 calendar days for standard (nonurgent) dental services. CMS Final Rule 0057-F emphasizes the need to improve interoperability, or the exchange of health information to achieve appropriate access to health records for patients, providers and payers.

To meet the streamlined time frame Humana must receive supporting clinical information **at the time of submission on predetermination requests for dental service.**

Best practices: For the most efficient claims processing, please submit different pretreatment plans separately.

- Example: If submitting to determine coverage for a bridge versus coverage for an implant, sending separate pretreatment plans can decrease the chance of delay due to conflicting services being submitted on the same tooth or arch.
- Please remember to verify patient's benefit coverage in Availity Essentials using the Humana Dental payer.

When submitting a predetermination, your treatment plan should include:

- ✓ A list of ADA nomenclature and codes
- ✓ Your written description of the proposed treatment
- ✓ Supporting pretreatment X-rays or other required diagnostics (please reference Humana claim attachment

guidelines)
- ✓ Itemized cost of the proposed treatment
- ✓ Any other diagnostic materials Humana Dental requests

For guidance on required clinical information and required pretreatment X-rays, please visit our dentist resources webpage, scroll down to the section for Guides, and review the list of Claim attachment guidelines. You can access these guidelines and those of other dental benefit plans in one central location by enrolling with Vyne Fastlook. To learn more, visit Vyne Dental. For DentalXchange, visit dentalxchange.com/solutions/for-providers.

Nondiscrimination and Notice of Availability

The U.S. Department of Health and Human Services (HHS) has made a final ruling in Section 1557 of the Affordable Care Act that prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities, including those receiving federal financial assistance. The Notice of Nondiscrimination rule became effective in November 2024, and the Notice of Availability became effective in July 2025. Entities must provide reasonable modifications for individuals with disabilities and provide appropriate auxiliary aids and services, free of charge and in a timely manner, when they are necessary to ensure an equal opportunity to participate for individuals with disabilities or individuals with limited English proficiency.

Dental practices can ensure compliance by posting notices in an easily visible and prominent physical location. Notices can be combined if provided they clearly inform individuals of their civil rights. To aid in fulfillment of this requirement, the Washington state Office of the Insurance Commissioner has provided a sample nondiscrimination notice template.

Noteworthy news

Consider network status when making patient recommendations

As a provider, there may be times when you choose to recommend your patient(s) to other trusted professionals for follow-up treatment. Humana Dental does not require a formal referral process. However, please remind your patient(s) that it is important that they confirm whether the provider you're recommending is participating in the network for their plan. If the provider is not in network and the patient chooses to seek treatment, it is advisable they confirm their out-of-network benefits prior to scheduling an appointment. This is important for all patients, but especially Humana members who may be on a MA plan and have a fixed or limited income.

Whitepaper: Don't underestimate younger generations' dental health decisions

There's a common misconception that younger generations, particularly Generation Z (18-27 years old) and millennials (28-43 years old), are less invested in their dental care compared to older generations. However, a recent Humana survey turns that thinking on its head. To learn more, view our whitepaper here.

2026 Current Dental Terminology code updates

The ADA adds, updates or deletes Current Dental Terminology (CDT®) codes as part of its annual code maintenance review. Humana is pleased to share detailed information regarding upcoming changes, which become effective Jan. 1, along with Humana's coverage approach for any newly introduced codes.

Please remember that plan coverage varies by product or group benefits, and member benefits and eligibility should be validated on our provider portal www.availity.com. You may also submit a pre-determination or call Humana at the phone number on the back of your patient's ID card. Please refer to our Provider Manual for more information.

Humana updates all fee schedules to include new ADA codes when a similar code was on the fee schedule.

- For example, if a fee schedule included D2931, then D2928 would be added with that fee.
- If the fee schedule did not have a similar/like code listed, we did not include the new code on the fee schedule.

For PPO-based plans, the new CDT codes have been added to our usual customary rate (UCR) tables that will help fee schedules pay to the 80% logic.

To see the full list of additions, deletions and changes online, please view the full list of CDT codes.

Additional benefit details are available on our dental resources page in the Benefits section. To see the full list of MA plans, select the appropriate link to Review DEN codes. Additional dental benefit information can be accessed using the link to find benefits resources.

Have questions?

How to reach the Humana provider call center

You can reach Humana Dental/Medicare Dental at 800-833-2223, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. Humana's automated customer care line provides claim and patient information. When calling, please have the following information handy:

- TIN
- Patient's name and date of birth
- Patient's Humana member ID number
- Date(s) of service

Helpful links

- Dental Provider Manual
- Medicare Dental Office Handbook 2026
- Dental Resources for Providers

Humana Dental Highlights is a quarterly publication for dental providers throughout the Humana network.