GUARDIAN

**Federal Health Insurance Marketplace Transparency in Coverage Reporting**

Federal Transparency in Coverage Reporting requires that Guardian Life Insurance Company of America, and its subsidiaries, First Commonwealth Insurance Company and Managed DentalGuard Inc., provide members with the following general information regarding certain aspects of coverage under Qualified Dental Plans sold though the federal Health Insurance Marketplace[1].

**OUT-OF-NETWORK LIABILITY & BALANCE BILLING**

*Balance billing occurs when an out-of-network provider bills a member for charges (other than copays, coinsurance, or deductibles) that are above the plans' reimbursable allowance for a given dental service.*

*For all dental plans, if a member is unable to use an in-network dentist due to a dental emergency or if a member cannot access an in-network provider because of scheduling or distance, we may pay the member's out-of-network claim as an in-network claim.*

*Preferred Provider Plans*
*In-network dentists are prohibited from balance billing. Members are responsible only for coinsurance or amounts applied to the deductible. Out-of-network dentists may balance bill and members will be responsible for any balance billed amounts.*

*Dental DHMO Plans*
*DHMO dentists and specialists are prohibited from balance billing. Members are responsible for patient charges, corresponding to covered procedures, listed on their schedule of benefits.*

**CLAIM SUBMISSION**

Preferred Provider Plans
*When a member receives dental care and treatment from a network provider, the network provider automatically submits the claim to us on the member's behalf.*

*When a member received dental care from a non-network provider, the provider may submit the claim to us as a courtesy. If a member needs to submit a claim, he or she may get a paper claim form by visiting MyDental.guardianlife.com or the member may call the customer service number on his or her identification card. The completed claim should be sent to the address shown on the claim form.*

*Claims must be submitted in a timely manner from date of service.*

*Forms available for Guardian Dental plans: https://MyDental.guardianlife.com/member-forms/*

*Claims can be mailed to: Claim Department*
*P.O. Box 254888*
*Sacramento, CA 95865*
*Contact Customer Service: 1-866-569-9900*

Dental DHMO Plans
*Claim forms are required for services performed on children under the age of 19. Claim forms are not needed for Adults over 19 years of age for a visit to a DHMO general dentist. Covered services are paid in full, subject to a patient charge for corresponding covered procedures, based on your schedule of benefits. For specialty services such as periodontal, endodontic, oral surgery covered services, a DHMO specialist will submit a claim to us on your behalf.*

*Forms available for Managed DentalGuard/First Commonwealth Dental: https://MyDental.guardianlife.com/member-forms/*

*Claims can be mailed to: Claim Department*
*P.O. Box 254888*
*Sacramento, CA 95865*

*Contact Customer Service: 1-866-569-9900*

*In the event that the insured obtains services from an Out-of-Network provider for an emergency, it is the member's responsibility to submit the claim to the carrier in a timely manner, from the date of service.*

**GRACE PERIODS**

Preferred Provider Plans & Dental HMO (DHMO) Network Plans

*A Grace Period is an amount of time during which insurance coverage will continue even though premium due for the period has not been paid. If claims are paid during this time and the member is terminated for non-payment, refunds will be requested. Our dental plans provide a 31-day Grace Period for payment of premium.*

*If a member receives federal premium subsidies, the dental plan provides a 90-day grace period. Claims incurred during the first month of the grace period are processed whether or not the due premium is paid. After the first month, any claim incurred during the grace period will be paid. If premium is not paid by the end of the third month, dental coverage will terminate at the end of the first month of the grace period; and any claim incurred during the second or third month becomes the member's responsibility.*

**RETROACTIVE DENIALS**

Preferred Provider Plans & Dental HMO (DHMO) Network Plans

*A retroactive denial is the reversal of a claim previously paid for which a member now becomes responsible for full payment. A retroactive denial may occur when a paid claim is denied due to nonpayment of premium.*

*To prevent retroactive denials:*

*- Pay your premium by the due date.*
*- Utilize the Pay Now feature for automatic payments*
*- Verify eligibility prior to appointment by calling Customer Service*
*- Elect a Preferred Provider if on a DHMO plan*

**RECOUPING OVERPAYMENTS**

Preferred Provider Plans & Dental HMO (DHMO) Network Plans

*A recoupment of an overpayment occurs when a billing error result is more premium being paid than actually required to maintain coverage for the billing period. If a member needs to obtain a premium refund due to an overpayment, he or she may call the customer service number on his or her identification card.*

**MEDICAL NECESSITY & PRIOR AUTHORIZATION -**

Preferred Provider Plans & Dental DHMO Plans

*Your PPO dental plan does not require prior authorization to receive network or covered out-of-network dental services.*

*Your Guardian DHMO dental plan does not require a referral or prior authorization to receive specialty services In-network. Emergency services do require prior authorizations to receive covered out-of-network services.*
*Your Access Dental plan requires a referral from your Primary Care Dentist for all specialty care and a preauthorization from the specialty provider. The only exception is for Emergency services.*

*Your dental plan does not determine medical necessity, except in the case of Pediatric Orthodontia. A determination will be made upon claim submission for medical necessity. Dental services are covered or excluded based on industry recognized American Dental Association ADA and CDT dental code schedules.*

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**EXPLANATION OF BENEFITS (EOB's)**

Preferred Provider Plans & Dental DHMO Plans

*An Explanation of Benefits, or EOB, is a document explaining what dental services were covered when a claim has been processed.*

*EOBs outline the type of care that a member received, the date the service was performed, a description of the service and claim number representing the type of service, the providers name and address, and the name of the patient. The EOB also lists the amount charged by the dentist and the amount we allow as a covered dental expense. It may also show any discounted fee that a dentist accepted as part of our contracted arrangement. Your DHMO dental plan will send an EOB when services are performed.*

*The total patient cost is also listed. This is remaining balance owed by the patient after we apply a member's dental plan's deductible, coinsurance and patient charge amounts. If a member received a type of dental care that is not covered by our dental plan, members must pay the amount in full.*

*EOBs show any corresponding codes that explain why a provider was not paid a certain amount. These codes are shown at the bottom, on the back or attached to the EOB. Additionally, the EOB explains how to begin the process of making an appeal.*

*You can obtain copies of your EOB's in your secure self-service module or by calling Customer Service at the number located on your ID Card.*

**COORDINATION OF BENEFITS (COB)**

Preferred Provider Plans & Dental DHMO Plans

*Coordination of Benefits (COB) occurs when a member is covered by more than one dental plan and a service is payable by two or more of those plans. COB makes sure that between all the dental plans, not more than 100% of a covered dental service is paid.*

*In COB, predefined rules determine which of the plans will pay its benefits first (the primary plan). Once the primary plan is identified, all other plans pay as secondary plans. The primary plan is responsible for claim payment in full, except for deductibles, coinsurance, patient charges and charges not covered. The secondary plan pays the balance of the claim up to the total allowed amount.*

*Generally, a plan that covers a person as an employee or as non working spouse is the primary plan. For dependents, the birthday of the parent that falls earlier in the year is the primary plan.*

[1] This information is a general summary of some of the key provisions of your Qualified Dental Plan. These provisions are determined on the actual contract language in the issued booklet-certificate.

*Preferred Provider Plans are underwritten by Guardian Life Insurance Company of America in Florida, Georgia, Illinois, Indiana, Louisiana, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, & Wisconsin.*

*Dental DHMO Plans in Florida & New York are underwritten by Guardian Life Insurance Company of America, in Illinois by underwritten by First Commonwealth Insurance Company, and in Texas and New Jersey by Managed Dental Guard Inc.*

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