Guardian

FEDERAL HEALTH INSURANCE MARKETPLACE TRANSPARENCY IN COVERAGE REPORTING

Federal Transparency in Coverage Reporting requires that The Guardian Life Insurance Company of America and its subsidiaries[1] provide members with the following general information regarding certain aspects of coverage under Qualified Dental Plans sold though the federal Health Insurance Marketplace[2].

OUT-OF-NETWORK LIABILITY & BALANCE BILLING

Balance billing means that a dentist who does not participate in our network can bill a member for charges (other than copays, coinsurance, or deductibles) that are above the amount paid toward the cost of treatment.

This occurs when members have a service performed by a dentist that is not participating in the dental plan's network and where state legislation prohibits us from requiring that a network dentist accept the applicable fee schedule amount.

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 will reimburse the member's out-of-network claim as an in-network claim only when state legislation requires that benefit reimbursement be made as if the member visited a dentist that participated in the network and the member had no option but to receive medically necessary covered treatment from an out-of-network provider. All other claims will be considered based on the group's out-of-network plan benefits.

Preferred Provider Plans - Dentists that participate in the PPO are prohibited from balance billing. Members are responsible only for copays, coinsurance or amounts applied to the deductible and any amount not paid, up to the provider's applicable fee schedule amount. Dentists that do not participate in the network 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 only for patient charges listed on their schedule of benefits.

CLAIM SUBMISSION

All claims should be submitted within 90 days from the date a dental service or supply was provided.

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

When a member receives dental care from a provider that does not participate in the network, 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 calling the customer service number on his or her identification card or by visiting:

https://dentalexchange.guardiandirect.com/member-forms/
https://dentalexchange.guardiandirect.com/wp-content/uploads/sites/3/2016/09/Guardian_Individual-Dental-Claim-Form.pdf

The completed claim form should be sent to the address shown on the claim form or by mailing to:

Guardian
PO Box 981587
El Paso, TX 79998-1587

Dental DHMO Plans
Claim forms are not needed for a visit to a DHMO general dentist since all covered services are paid in full, subject to a patient charge. For specialty services such as periodontal, endodontic, and oral surgery covered services, a DHMO specialist will submit a claim to us on your behalf. Claims forms are required for orthodontic treatment of children under the age of 19.

GRACE PERIODS

Preferred Provider Plans & *Dental DHMO Plans*
A Grace Period is the time during which dental coverage will continue even though premium due for the period has not been paid.

Our dental plans provide a 31-day Grace Period for payment of premium. During the Grace Period, claims are paid until the end of the 31-day period.

After 31 days, no claims are paid unless all premium due is received. If premium is not received, dental coverage will terminate as of the first day of the Grace Period.

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 held and not paid. If the required period premium is paid on or before the third month, any pended claims will be released for processing. 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 DHMO 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 later denied due to nonpayment of premium. Retroactive denials can be limited in frequency by paying premium on time.

RECOUPING OVERPAYMENTS

Preferred Provider Plans & *Dental DHMO Plans*
A recoupment of an overpayment occurs when a billing error results 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

Medical necessity is used to determine dental care and treatment that is reasonable, necessary and appropriate based on clinical standards of dental care.

Your dental plan will cover treatment when it meets the dental plan guidelines for coverage. Dental services are covered or excluded based on industry recognized American Dental Association ADA and CDT dental code schedules and the dental plan guidelines.

Predetermination for Preferred Provider Plans
A predetermination of benefits is an explanation of the allowable dental policy benefits prior to the services being performed. A member or provider can submit a request for a predetermination using a standard dental claim form. Predeterminations can be submitted electronically, faxed or mailed to us. A predetermination is recommended, but not required, for a specific treatment plan or when services are over $300. Predeterminations must be submitted in writing and will be processed within 15 business days of receipt (for standard care) or within 24 hours (for emergency care). Predeterminations do not expire.

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

Referrals for Dental DHMO Plans
Your DHMO dental plan may require a referral to receive specialty network services. It also requires prior authorizations to receive covered out-of-network services except in the case of a dental emergency. If you do not get a referral for out-of-network services may result in your treatment being denied. Prior authorization and referrals will be processed within 15 business days of receipt (for standard care) or within 24 hours (for emergency care).

EXPLANATION OF BENEFITS (EOBS)

Preferred Provider Plans & *Dental DHMO Plans*

An Explanation of Benefits, or EOB, is a document we provide after consideration of a submitted claim, which explains what dental services were covered, our payment amount and a member's remaining financial responsibility.

EOBs outline the type of care that a member received, the date the service was performed, a description of the service and CDT code 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 will also show any discounted fee that a dentist accepted as part of our contracted arrangement. Your DHMO dental plan will only send an EOB when there is member liability or when services are performed by a Specialist.

The total patient responsibility is also listed. This is the remaining balance owed by the patient after we apply a member's dental plan's deductible, coinsurance, calendar/policy year maximum 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 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.

COORDINATION OF BENEFITS (COB)

Preferred Provider Plans & *Dental DHMO Plans*

Coordination of Benefits (COB) occurs when a member is covered by one or more dental plans 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 for covered services.

Generally, a plan that covers a person as an employee or as a 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] *Preferred Provider Plans are underwritten by Guardian® and Premier Access Insurance Company.*

[1]*Dental DHMO Plans are underwritten by Guardian®, First Commonwealth Inc. and its subsidiaries, Access Dental Plan, and Managed Dental Guard Inc.*

[2]*This information is a general summary of some of the key provisions of your Qualified Dental Plan. The actual contract language in the issued booklet-certificate will govern in any discrepancy between this information*