Federal Health Insurance Marketplace Transparency in Coverage Report

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 through the federal Health Insurance Marketplace.[2]

Out-of-network Liability and Balance Billing

Balance billing means that a dentist who does not participate in our network bills 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

A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly.

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, follow these steps:

1. Complete a claim form Claim Form
2. Attach an itemized bill from the provider for the covered service.
3. Make a copy for your records.
4. Mail your claim to the address below.

Guardian
PO Box 981587
El Paso, TX 79998-1587

5. Alternatively, you can send the information by fax to 916-388-3604

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

You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be cancelled. If you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly.

If you have an individual HMO plan, we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period.

If you are enrolled in an individual health care plan offered on the Health Insurance Marketplace and you receive an advance premium tax credit, you will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.

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 Overpayment

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®

1 Dental DHMO Plans are underwritten by Guardian®, First Commonwealth Inc. and its subsidiaries, 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