

The Guardian Life Insurance Company of America provides an Exclusive Provider Organization (EPO) insurance policy for individual dental coverage, governed by New York State laws. The policy is effective from the date approved by the insurer and automatically renews annually on January 1, unless terminated by either party with a 30-day written notice. Coverage is restricted to in-network benefits, necessitating that members receive care exclusively from Participating Providers within the Managed DentalGuard (MDG) network, with services arranged or authorized by a Primary Care Dentist (PCD). Members are responsible for costs incurred from Non-Participating Providers. The policy includes a ten-day satisfaction guarantee for cancellation and premium refunds. Covered Services must be medically necessary, provided by a Participating Provider, and adhere to benefit limitations. Cost-sharing involves copayments, with no deductibles or coinsurance, and an out-of-pocket limit applies to pediatric dental essential health benefits. Exclusions include certain dental services, and members must select a PCD and obtain referrals for specialist care, although emergency dental care does not require a referral. Members can change their PCD by contacting the insurance provider, effective the first day of the following month, and must settle any outstanding fees with the current PCD before the transfer.

The policy does not require preauthorization for covered services, but benefits are subject to medical management reviews to ensure medical necessity. Coverage extends to the subscriber and their family members, including children up to age 26, with specific provisions for mentally or physically incapacitated children. Open enrollment occurs annually from November 1 to January 31, with special enrollment periods for certain life events. Pediatric dental care coverage includes a range of services, while adult dental care covers similar services. Exclusions encompass services related to felonies, cosmetic procedures, care outside the U.S., and experimental treatments, among others. Claims must be submitted within 180 days of service, with specific requirements for information included. Grievance procedures are available for non-medical necessity issues, and members can appeal determinations regarding medical necessity.

Utilization reviews are conducted for concurrent and retrospective reviews, with specific timelines for decision-making. If a determination is not made within the specified time frames, it is considered an adverse determination, allowing for an internal appeal. External appeals are available for denials based on medical necessity, requiring certification from the attending physician regarding the appropriateness of the recommended provider. The policy outlines the appeal process, emphasizing timely communication and the rights of the insured.

Coverage may terminate automatically upon the subscriber's death, divorce, or when dependents reach age limits. The subscriber can terminate the policy with 14 days' notice, while the insurer can terminate it with 30 days' notice for non-payment of premiums or fraud. Upon termination, benefits for ongoing dental procedures will be extended for at least 30 days. The policy includes provisions for premium refunds, overpayments, renewal, and reinstatement, with specific guidelines for administrative processes. Legal actions must be initiated within 60 days of claim submission, and disputes are to be resolved in New York courts. The policy ensures confidentiality regarding the subscriber's dental records and provides translation services for non-English speaking members.