CHIP Member Handbook

What you need to know about your Dental Benefits

Premier Access Insurance Company
Combined Evidence of Coverage and Disclosure Form Utah Medicaid

Updated September 2023

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call 877-854-4242 (TTY 888-346-3162). The call is free.

Other formats

You can get this information for free in other formats, such as Braille, large print and audio within 5 business days at no charge. Call 877-854-4242 (TTY 888-346-3162). The call is free.

Interpreter services

For free interpreter, linguistic and cultural services and help available 24 hours a day, 7 days a week, or to get this handbook in a different language, call 877-854-4242 (TTY 888-346-3162). The call is free.

ATTENTION: If you need help in your language call 1-877-854-4242 (TTY: 1-888-346-3162). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-877-854-4242 (TTY: 1-888-346-3162). These services are free of charge.

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-877-854-4242 (TTY: 1-888-346-3162) También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-877-854-4242 (TTY: 1-888-346-3162). Estos servicios son gratuitos.

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

English ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 877-541-5415 (TTY: 888-346-3162).	Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-541-5415 (TTY: 888-346-3162).
Chinese **注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**877-541-5415（TTY：888-346-3162）。	Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-541-5415 (TTY: 888-346-3162).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-541-5415 (TTY: 888-346-3162)번으로 전화해 주십시오.	Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877-541-5415 (TTY: 888-346-3162).
Farsi **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 877-541-5415 (TTY: 888-346-3162) تماس بگیرید.	Arabic ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-854-4242 (رقم هاتف الصم والبكم: 1-888-346-3162).
Haitian-Creole ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 877-541-5415 (TTY: 888-346-3162).	Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877-854-4242 (TTY: 800-735-2929).
French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 877-541-5415 (ATS : 888-346-3162)	Italian ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 877-541-5415 (TTY: 888-346-3162).

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877-541-5415 (телетайп: 888-346-3162).	Armenian ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 877-541-5415 (TTY (հեռատիպ)՝ 888-346-3162):
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 877-541-5415 (TTY: 888-346-3162).	Portuguese ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 877-541-5415 (TTY: 888-346-3162).

Welcome to Premier Access Utah Dental CHIP!

Thank you for joining Premier Access Insurance Company (Premier Access). Premier Access is a dental plan for people who have Utah CHIP. We work with the Utah Department of Health and Human Services to help you get the dental care you need.

Member Handbook

This Member Handbook tells you about your coverage under Premier Access. Please read it carefully. It will help you understand and use your Benefits and services. It also explains your rights and responsibilities as a member of Premier Access.

This Member handbook is also called the Evidence of Coverage (EOC). It is only a summary of Premier Access rules and policies. If you would like to learn the exact terms and conditions of coverage, you may request a copy of the contract from Customer Service.

Call 877-854-4242 (TTY 888-346-3162) to ask for a copy of the Member Handbook at no cost to you or visit our website at https://portal.premierlife.com to view the Member Handbook.

Contact us

We are here to help. If you have questions, call 877-854-4242 (TTY 888-346-3162). We are here from 8:00am to 5:00pm MST. The call is free.

Thank you,

Premier Access Insurance Company
10400 N. 25th Ave
Suite 200
Phoenix, AZ 85021

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

Premier Access Insurance Company

PO BOX 38300
Phoenix, AZ 85069-8300

https://portal.premierlife.com

Customer Service:
(877) 854-4242

TTY:
(888) 346-3162

ATTENTION: If you need help in your language call 1-877-854-4242 (TTY: 1-888-346-3162). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-877-854-4242 (TTY: 1-888-346-3162). These services are free of charge.

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Notice of Non-discrimination

Premier Access Insurance Company complies with Applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premier Access Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Premier Access Insurance Company Provides:

Free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call 1-877-854-4242.

If you believe that Premier Access Insurance Company has failed to provide these services or discriminated against you in another way on the basis of race, color, national origin, age, disability, or sex, you can file a Grievance with the Grievance Coordinator.

Grievance and Appeals Department
P.O. Box 38300, Phoenix, AZ 85069
Toll Free: 1-888-346-3162 (TTY 1-888-346-3162)
ag@avesis.com

You can file a Grievance in person or by phone, mail, fax, or email. If you need help filing a Grievance, a Grievance Coordinator is available to help you.

You can also file a civil rights Complaint with the U.S. Department of Health and Human

Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**

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Language Services

How can I get help in other languages?

Call Member Services at (877) 854-4242 if you speak a language other than English, are deaf, blind, or have a hard time hearing or speaking. We will find someone who speaks your language, free of charge. We can also provide materials in other formats such as large print, Braille, or audio.

If you are hard of hearing, call Utah Relay Services at 711 or (877) 854-4242. Utah Relay Services is a free public telephone relay service or TTY/TTD. If you need Spanish relay services, call (888) 346-3162 for Spanish Relay Services.

If you would rather speak a different language, please tell your dentist's office or call our Member Services. We can have an interpreter go with you to your dental visit. We also have many dentists in our network who speak or sign other languages.

You may also ask for our documents in another written language by calling our Member Services team.

Rights and Responsibilities

What are my rights?

You have the right to:

- Have information presented to you in a way that is easy to understand, including help with language needs, visual needs, and hearing needs.
- Be treated fairly and with respect.
- Have your health information kept private.
- Get information on all treatment options and alternatives.
- Make decisions about your dental care, including agreeing to treatment.
- Take part in decisions about your dental care, including the right to refuse treatment.
- Ask for and get a copy of your dental record.
- Ask that your dental record be corrected or changed, if needed.
- Get dental care regardless of race, color, national origin, sex, sexual orientation, gender identity, religion, age, or disability.
- Get information about grievances, appeals, and State fair hearings.
- File a grievance or request and appeal.
- Get emergency care at any hospital or other setting.
- Get emergency care 24 hours a day, 7 days a week.
- Not feel controlled or forced into making dental decisions.
- Ask how we pay your providers.

- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience or retaliation. This means you cannot be held against your will. You cannot be forced to do something you do not want to do.
- Use your rights at any time and not be treated badly if you do. This includes treatment by Premier Access, your dental providers, and the State Medicaid and CHIP agency.
- To be given dental care services that are the right kind of services based on your needs.
- To get dental services that are covered by CHIP, fairly easy to get to, and accessible to all members. All members include those who may not speak English very well, or have physical or mental disabilities.
- To get covered dental services within 30 days for routine, non-urgent care, and within 2 days for urgent care that is not life threatening.
- To get a covered dental service from an out-of-network provider if we cannot provide the service.
- A second opinion at no charge.
- Indian members may obtain covered dental services directly from an Indian health care provider.
- To receive dental services in accordance with requirements for access, coverage and coordination of medically necessary services.

What are my responsibilities?

Your responsibilities are to:

- Follow the rules of your dental plan.
- Read your CHIP Member Handbook.
- Show your CHIP card each time you get dental care.
- If you must cancel an appointment, call your dentist 24 hours before the appointment.
- Respect the staff and property at your provider's office.
- Provide correct information to your dentists, and your CHIP plans.
- Understand the dental care you need.
- Use dentists and facilities in the Premier Access CHIP network.
- Tell us if you get a dental bill.
- Pay your copays, deductibles, and quarterly premiums.
- Call the Department of Work Force Services (DWS) if you change your address, family status, or other health care coverage.

Advance Directives

You have a right to make decisions about your dental care. An advance directive is a form you can fill out to protect your rights. You have a right to accept or refuse treatment. You also have the right to plan and direct the types of health care you may receive in the future.

There are four types of Advance Directives:

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

- Living Will (End of life care)
- Medical Power of Attorney
- Mental Healthcare Power of Attorney
- Pre-Hospital Medical Care Directive (Do Not Resuscitate)

Living Will: A Living Will is a document that tells doctors what types of services you do or do not want if you become very sick and near death and cannot make decisions for yourself.

Medical Power of Attorney: A Medical Power of Attorney is a document that lets you choose a person to make decisions about your health care when you cannot do it yourself.

Mental Healthcare Power of Attorney: A Mental Healthcare Power of Attorney names a person to make decisions about your mental health care in case you cannot make decisions on your own.

Pre-Hospital Medical Care Directive: A Pre-Hospital Medical Care Directive tells providers if you do not want certain lifesaving emergency care that you would get outside a hospital or in a hospital Emergency Room. It might also include services provided by other emergency response providers, such as firefighters or police officers. You must complete a special orange form. You should keep the completed orange form where it can be seen.

Contacting My CHIP Dental Plan

Who can I call when I need help?

Our Member Services team is here to help you. We can answer your questions. You can call us at (877) 854-4242 from Monday through Friday, from 8:00 AM to 5:00 PM MST.

We can help you:

- Find a dentist
- Find a dental specialist
- Change dentists
- With questions about bills
- Understand your benefits
- Find a dental specialist
- With a complaint or an appeal
- With any other question

You can also find us online at **https://portal.premierlife.com.**

CHIP Benefits

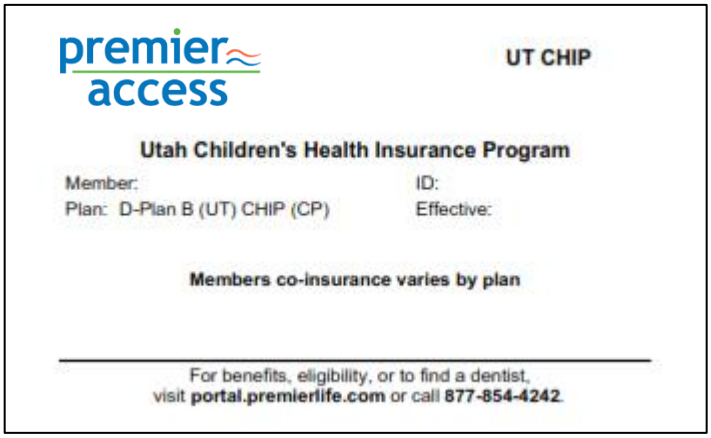
How do I use my CHIP dental benefits?

Each CHIP member will get a Utah CHIP dental card.

You should get your CHIP dental card in the mail within 21 days of being enrolled. Always show your CHIP dental card before you receive services or get a prescription filled. Always make sure that the provider accepts your CHIP dental plan before you get services or you may have to pay for the service. A list of covered services is found on page 24.

What does my Utah CHIP dental card look like?

The Utah CHIP dental card is wallet-sized and will show the member's name, CHIP ID number and benefit plan. Your Premier Access Utah CHIP dental card will look like this:



DO NOT lose or damage your card or give it to anyone else to use. If you lose or damage your card, call Member Services (877) 854-4242 to get a new card.

Can I see my CHIP benefits online?

Yes, you can see your CHIP dental plan benefits and other plan information online at **https://portal.premierlife.com.** For more information on benefits, call Member Services (877) 854-4242. You may also view your CHIP coverage and plan information online at **mybenefits.utah.gov.**

For additional information on accessing or viewing benefit information, please visit **mybenefits.utah.gov** or call 1-844-238-3091.

Finding a Provider

What is a Primary Dental Provider (PDP)?

A Primary Dental provider (PDP) is the dentist who gives you or your child services that prevent or treat dental problems. A PDP can be a general dentist or a dentist who treats children. Your PDP knows your child's dental history. Your PDP can send you to a specialist for more complex dental problems. With a PDP, your dental needs will be managed from one place.

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

How do I choose a Primary Dental Provider (PDP)?

It is important for you to find a dentist. Having a primary care dentist will help you receive care on a regular basis. Choosing a primary dental provider is recommended. Children should have a dental visit no later than their 1st tooth or 1st birthday.

You may choose any dentist who is on our network. In-network providers are listed in our provider directory. The provider directory can be found online at portal.premilerlife.com. Click “Search for Providers”. Enter your plan type (CHIP). You can search for dentists by zip code or by name. Click “Additional details” for more search options. If you need help choosing a dentist, you may call Member Services at (877) 854-4242 and someone will help you. Tell us if you have a special need related to your dental care.

How do I change my Primary Dental Provider (PDP)?

You are not required to notify Premier Access when you choose a new dentist or PDP. However, you will need choose any dentist who is in the Premier Access CHIP network. In-network providers are listed in our provider directory. The provider directory can be found online at portal.premilerlife.com. Click “Search for Providers”. Enter your plan type (CHIP). You can search for dentists by zip code or by name. Click “Additional details” for more search options. If you need help finding a new dentist, you may call Member Services at (877) 854-4242 and someone will help you. Tell us if you have a special need related to your dental care.

Cost Sharing

What is cost sharing?

Cost sharing is your share of costs for service that you must pay for out of your own pocket. This includes copayments, coinsurance, deductibles, and premiums.

What is a co-payment (co-pay)?

A copay is a fixed amount you must pay for some services. This is usually done at the time of service.

For additional copay information, refer to the **CHIP Co-pay Chart** on page 17. The copay plan you are assigned will be listed on your CHIP medical card and on your myCase account through the Department of Workforce Services.

What is coinsurance?

Some services have a coinsurance. A coinsurance is a percentage of the total bill that you are responsible to pay. Coinsurance percentage can be different depending on the service.

What is a deductible?

Some services have a deductible. A deductible is a set amount during a plan year that you must pay for before your plan begins to pay the remaining cost of the bill. Once the deductible has been paid, you no longer have a deductible for the remainder of the plan year. The deductible plan year starts every July 1st and ends on June 30th every year.

What is a premium?

In addition to other cost sharing including co-pays, coinsurance and deductibles, most members must pay a premium. A premium is the amount you pay to get CHIP benefits. For information about your CHIP premium, call the DWS at 1-866-435-7414.

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What is an out-of-pocket Maximum?

An out-of-pocket maximum is the most you pay for cost sharing during your benefit period. The maximum is based on your household income. The benefit period is the 12-month period that begins with your first month of CHIP eligibility. Premiums, deductibles, coinsurance, and copays all count toward the out-of-pocket maximum.

DWS will tell you what your out-of-pocket maximum amount is for each benefit period. If you are not sure what your out-of-pocket maximum amount is, call DWS at 1-866-435-7414.

What happens when I reach my out-of-pocket maximum?

Once you reach your out-of-pocket maximum, we will send your household new CHIP dental cards and a letter notifying you that your household will no longer have to pay cost sharing for your benefit period. Until your ID cards are received, you can show a copy of the letter to your provider as proof you do not owe a copay.

If you have questions about whether you have reached your household's out-of-pocket maximum call 323-801-1094 and a representative will help you.

What happens when I have used the $1000 annual maximum or the $1000 lifetime orthodontic maximum benefit?

- Once you have used the maximum annual benefit of $1000, the dental plan will not pay for any more services until the next benefit year. The $1000 annual maximum renews each benefit year and can be used for all dental services, except orthodontics.
- Once you have used up the $1000 lifetime orthodontic maximum, the benefit is exhausted and will not renew. Since orthodontic treatment typically costs more than $1000, once the $1000 benefit is used, the member is responsible for the remaining balance up to the allowed CHIP fee. However, you must agree in writing that you will pay for the service before you get the service.

Who does not have to pay cost share?

- Alaska Natives
- American Indians
- Those who have reached their out-of-pocket maximum for their dental period

When do I pay a copay?

You will pay a copay for:

- Basic Services
- Major Services
- Orthodontics
- Specialists

What services do not have a copay?

- Preventive services

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CHIP Dental Copay Chart

CHIP Copay Chart

Benefits (Per Plan Year)	Co-Pay Plan B*	Co-Pay Plan C*
Out-Of-Pocket Maximum	5% of family's annual gross income, including dental expenses**	5% of family's annual gross income, including dental expenses**
Premium*	$30/family/quarter	$75/family/quarter
Pre-Existing Condition	No waiting period	No waiting period
Deductible*	$0	$50/child; $150/family
Maximum Benefit • Preventive, Basic & Major services per child, per year	$1,000 per plan year, per child***	$1,000 per plan year, per child***
Preventive Services • Routine exams • Cleanings (2 per year) • Topical fluoride • X-rays	$0	$0
Basic Services • Fillings • Extractions • Oral surgery • Endodontics • Periodontics	5% of approved amount	20% of approved amount after deductible
Major Services • Crowns • Bridges • Dentures	5% of approved amount	50% of approved amount after deductible
Orthodontics • Requires prior authorization covered only if medically necessary	Minimum of 5% of approved amount (Plan pays $1,000 lifetime benefit maximum**) Requires prior authorization	Minimum of 50% of approved amount (Plan pays $1,000 lifetime benefit maximum**) Requires prior authorization
Specialists • Endodontists • Oral Surgeons • Periodontists • Pediatric Specialists • Prosthodontists	5% of approved amount	Talk to your dental plan for an estimate of additional charges.

* Co-pay plans are based on your income. American Indian/Alaska Natives will not be charged co-pays, premiums, or a deductible. Member pays remaining portion of the allowed fee after plan has paid the maximum annual benefit.

** Orthodontic services over the maximum dental benefit do not count toward the annual out-of-pocket maximum benefit. Member pays remaining portion of the allowed fee after plan has paid the maximum orthodontic benefit.

*** The Maximum Dental Benefit and Orthodontic Lifetime Maximum applies for all members, including American Indian/Alaska Natives. Member pays remaining portion of the allowed fee after plan has paid the maximum orthodontic benefit.

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What should I do if I get a dental bill that should be covered by CHIP?

If you get a bill for services that you believe should be covered by CHIP, call Member Services 877-854-4242. Do not pay the bill until you talk to Member Services. You may not get a refund if you pay the bill on your own. You should never have to pay for PPE (personal protective equipment). This is included in the cost of your covered dental services and dentists cannot charge you for it.

You will have to pay a dental bill if:

- You are not eligible for CHIP on the day of service.
- You get a service that is not covered by CHIP or that exceeds the CHIP benefit limit.
- You ask for and get services during an appeal or State Fair Hearing and the decision is not in your favor.
- You do not show your CHIP ID Card before you get dental care.
- You are not eligible for CHIP.
- You get care from a dentist who is not with your dental plan, or is not enrolled with Utah CHIP (except for Emergency Services).
- You have reached your annual maximum benefit or lifetime orthodontic benefit and agreed, in writing, to pay for services before receiving the treatment.

Emergency Dental Care

What is a dental emergency?

A dental emergency is a condition that needs to be treated right away. An emergency is when you think your life is in danger, a body part is hurt badly, or you are in great pain.

What should I do if I have a dental Emergency?

If you have a dental emergency, first, contact your dentist. Most offices have an emergency phone number. If you do not have a dentist or do not get a response from yours, call Premier Access for assistance during regular business hours. If after hours, and if you cannot wait until regular business hours, call 911 or go to the closest emergency room.

In accordance with the State of Utah, emergency services provided in the dental office are covered under the CHIP program. Premier Access is not responsible for emergency services performed in a hospital or urgent care facility.

What if I have questions about poison danger?

For poison, medication, or drug overdose emergencies or questions, call the Poison Control Center at 1-800-222-1222.

Will I have to pay for dental emergency care?

Possibly. Let us know if you have to pay part of the bill above your co-pay. Send us a copy of the bill so we can pay for covered services. If you get or pay a bill, send a copy to us.

Premier Access insurance Company
Attn: Claims
P.O. Box 38300
Phoenix, AZ 85069-8300

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

If you are seen in the Emergency Department or Urgent Care for pain and infection in the mouth, your co-insurance applies. If you are seen in a dental office, the regular co-pay/co-insurance applies to dental services.

What should I do after I get emergency care?

Call us as soon as you can after getting emergency care. Also notify your Primary Dental Provider (PDP) to tell them about your emergency care visit.

Dental Specialists

What if I need to see a dental specialist?

If you need a service that is not provided by your Primary Dental Provider (PDP), you can see a dental specialist in the network. Services must be medically necessary and a covered benefit.

You may go directly to the in-network specialist if you have one. All benefit criteria must be met, including prior authorization.

You can search for in-network dentists or specialists in our provider directory. The provider directory can be found online at portal.premilerlife.com. Click “Search for Providers”. Enter your plan type (CHIP). You can search for dentists by zip code or by name. Click “Additional details” for specialties and more search options.

If you need help finding a specialist or have trouble getting in to see a dental specialist when you need one, call us at (877) 854-4242 for help.

Scheduling a Dental Appointment

How long does it take to make a dental appointment?

You should be able to get in to see a dentist:

- Within 30 days for routine, non-urgent appointments.
- Two days for urgent care that can be treated in a dentist’s office.

Prior Authorization

What is prior authorization?

Some services must be pre-approved by Premier Access before they will be paid. Approval to be paid for that service is called prior authorization.

If you need a service that requires prior authorization, your dentist will ask Premier Access to approve the service. If we do not approve payment for a service, you may appeal the decision. Please call our Member Services at (877) 854-4242 if you have any questions.

You may have to pay if you agreed to the treatment, in writing, before the treatment begins. If you see a non-network dentist, services must be approved by Premier Access before treatment.

Prior authorization is not a guarantee of payment for service. Non-emergency treatment begun prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member or Premier Access. Pre-authorizations are required on the following services:

- Crowns & Inlay/onlay restorations
- Core build ups and post and core procedures
- Some Endodontic procedures
- Surgical extractions and other surgical services
- Periodontal scaling
- Dentures/partials
- Orthodontics

If approved, the pre-authorization is valid for 180 days. If the service is not completed in 180 days, you will need to get a new pre-authorization.

Time frames for processing prior authorizations are:

- Standard – 14 calendar days
- Expedited – 72 hours

Other Dental Insurance

What if I have other dental insurance?

If you are covered by CHIP, you cannot have other insurance and be covered by CHIP unless the insurance is a limited coverage plan (such as a dental or vision only plan). You must notify the Department of Workforce Services (DWS) that you have other insurance within ten (10) days of enrollment with another insurance plan. You can call DWS at 1-866-435-7414.

DWS will review your insurance to determine if you will continue to qualify for CHIP. If your CHIP case closes, notify your dental providers to bill your other insurance instead of CHIP.

Adverse Benefit Determinations, Appeals, Grievances, and State Fair Hearings

What is an adverse benefit determination?

An adverse benefit determination is when we make a decision that is not in your favor. Types of adverse determinations are when we:

- Deny or limit approval of a requested service.
- Deny payment or pay less services you received.
- Lower the number of services we had approved, or end a service that we had approved.

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

- Do not make a decision on an appeal or grievance in a timely manner.
- Do not provide you with a dental appointment in a timely manner.
- Said you have to pay a financial liability. Financial liabilities include copays, coinsurance, deductibles, and premiums.

We will send you a notice of adverse benefit determination if one of the above happens. If you do not receive one, contact Member Services and we will send you one.

What is an appeal?

If you do disagree with the adverse benefit determination, you, your provider, or your authorized representative can request an appeal. An appeal is the review that Premier Access does of the adverse benefit determination.

How do I request an appeal?

You, your provider (with your written consent) or your authorized representative may request an appeal. The person requesting the appeal can do so by calling us or sending the appeal request in writing. The phone number is (877) 854-4242. The mailing address is

Premier Access
Attn: Grievances/Appeals
P.O. Box 38300
Phoenix, AZ 85069

The Appeals Dept. fax number is (855)-691-3243

An appeal request form is available on our website at **https://portal.premierlife.com** and at the back of this handbook.

A request for an appeal will also be accepted by email: **ag@avesis.com**

You must request the appeal within 60 days from the notice of adverse benefit determination notice. If you need help requesting an appeal, call us at (877) 854-4242. If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or 1-800-346-4128.

How long does an appeal take?

You will be given written notice of our decision within 30 calendar days from the date we get your appeal request. You will be notified in writing if we need more time to make a decision on your appeal request. If you, or your provider is concerned that waiting 30 days could be harmful to your health, call us at (877) 854-4242 and ask for a quick appeal.

What is a quick appeal?

A quick appeal means we will make a decision on your appeal within 72 hours after we receive it. If we do not agree that you need a quick appeal, we will send you a letter and explain why.

How do I request a quick appeal?

Call us at (877) 854-4242 or write to us at:

Premier Access
Attn: Grievances/Appeals
P.O. Box 38300
Phoenix, AZ 85069

What happens to the dental service related to my appeal request during the appeal?

You can request to continue your services during an appeal. If the appealed decision is not in your favor you may have to pay for the service.

What is a State Fair Hearing?

A State Fair Hearing is a process with the State Medicaid agency that allows you to explain why you believe Premier Access CHIP appeal decision should be changed. You, your authorized representative, or your provider, can ask for a State Fair Hearing after you get the notice of our appeal decision.

How do I request a State Fair Hearing?

When we tell you about our decision on your appeal request, we will tell you how to ask for a State Fair Hearing if you do not agree with our decision. We will also give you the Form to Request a State Fair Hearing to send to Medicaid. The form must be sent to Medicaid no later than 120 calendar days from the date on our appeal decision notice.

What is a grievance?

A grievance is a complaint about anything other than an adverse benefit determination. You have the right to file a grievance and tell us about your concerns. You can file a grievance about concerns related to your dental care such as:

- When you do not agree with the amount of time that it took for Premier Access to make a service authorization decision.
- Whether care or treatment is appropriate.
- Access to care.
- Quality of care.
- Rudeness by a provider or staff.
- Any other kind of problem you may have with us, your dental provider, or health care services.

How do I file a grievance?

You can file a grievance at anytime. If help is needed to file a grievance, call us at (877) 854-4242. If you are deaf or hard of hearing, you can call Utah Relay Services at 711 or 1-800-346-4128

You can file a grievance either over the phone or in writing. To file by phone, call Member Services at (877) 854-4242. To file a grievance in writing, please send your letter to:

Premier Access
Attn: Grievances/Appeals
P.O. Box 38300
Phoenix, AZ 85069

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

We will let you know of our decision about your grievance within 90 days from the day we get your grievance. Sometimes we might need more time to make our decision. We can take up to another 14 calendar days to make a decision. If we need more time to make a decision, we will let you know by phone or in writing within two days.

Fraud, Waste, and Abuse

What is health care fraud, waste, and abuse?

Doing something wrong related to CHIP could be fraud, waste or abuse. We want to make sure your health care dollars are used the right way. Fraud, waste and abuse can make health care more expensive for everyone.

Let us know if you think a dental care provider or a person getting CHIP is doing something wrong.

Some examples of fraud, waste and abuse are:

By a Member

- Letting someone else use your CHIP card
- Changing the amount or number of refills on a prescription
- Lying to get medical, dental, mental health, or pharmacy services

By a Provider

- Billing for services or supplies that have not been provided
- Overcharging a CHIP member for covered services
- Not reporting a patient's misuse of a CHIP card

How can I report fraud, waste, and abuse?

If you suspect fraud, waste or abuse, you may contact:

- Internal compliance
- Premier Access Insurance Company
  Fraud, Waste and Abuse
  P.O. Box 38300
  Phoenix, AZ 85069
  Fraud Hotline: 1-855-704-0435
- Provider Fraud
- The Office of Inspector General (OIG)
  Email: **mpi@utah.gov**
  Toll-Free Hotline: 1-855-403-7283
- Member Fraud
- Department of Workforce Services Fraud Hotline
  Email: **wsinv@utah.gov**
  Telephone: 1-800-955-2210

You will not need to give your name to file a report. Your benefits will not be affected if you file a report.

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

Emergency Transportation Services

How do I get to the hospital in an emergency?

If you have a serious medical problem and it's not safe to drive to the emergency room, call 911. CHIP covers ambulance services.

Amount, Duration and Scope of Benefits Covered by Your Dental Plan

Dental services covered by Premier Access:

- Preventive services: Check-ups, x-rays and cleanings every six months
- Tooth sealants and fluoride treatments
- Fillings for affected teeth
- Root canal treatment for certain teeth
- Remove the soft inner part of the tooth (pulp) for infected baby teeth
- Pulling teeth
- Dentures, partial dentures
- Space maintainers for children with missing teeth
- Orthodontic care
- Some specialty care or surgical centers for care under general anesthesia
- I.V. sedation and oral sedation
- Oral surgery
- Emergency services
- After hours office visits

CHIP covers medically necessary services.

What is a Medically Necessary Service?

To determine if dental care is a Medically Necessary Service, Premier Access considers:

- The prevention, diagnosis and treatment of a disease, condition and/or disorder that results in health impairments and/or disability.
- The ability for a member to receive age-appropriate growth and development.
- The ability for a member to attain, maintain or regain functional capacity.
- The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of their choice.

Premier Access follows Utah State Medicaid guidelines and requirements and is no more restrictive than the state Medicaid program on covered dental services, number of services or how often you can have services.

Can I get a service that is not on this list?

No, CHIP does not pay for non-covered services.

Dental services not covered by Premier Access CHIP:

A non-covered service is one not covered under CHIP. You may have to pay for services that are NOT covered, such as:

- Treatment of injuries or illness covered by workers' compensation or employers' liability laws
- Surgery and dental services for cosmetic reasons
- Services for congenital (hereditary) or developmental (following birth) problems
- Treatment to restore tooth structure lost from wear, erosion or abrasion
- Services that were started before the member was covered by CHIP
- Pharmacy
- Experimental procedures
- Hospital and surgical facility charges
- Some types of anesthesia
- Extra oral grafts
- Treatment performed by someone other than a dentist or a person who works under the supervision of a dentist.
- Oral hygiene education
- Extra x-rays
- Cancer screening
- Charges for missed appointments
- Services covered by another dental plan
- Limited orthodontic and removable appliance therapies

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

- Habit control appliances (mouth guards)
- Services for problems with temporomandibular joints (TMJ)
- Non-emergency services received in the emergency room
- Non-emergency or non-urgent services from a non-network dentist (with no prior approval)
- Services over your annual maximum dental benefit
- Services that are not medically necessary

If you choose a non-covered service, you must pay for it. Your dentist must tell you before treatment is done. If you agree to the service, it must be in writing before you get services. The amount you agree to pay and the services being done must be in writing. The dentist will bill you for the non-covered services.

Benefit Limits

You have an Annual Maximum Dental Benefit of $1,000 per plan year. This is the total we will pay for your dental care per plan year.

You must be approved to get orthodontic treatment. The Orthodontia Lifetime Maximum is $1,000. This is the total we will pay for you under CHIP. You must pay the cost of treatment above this amount.

The Orthodontic Lifetime Maximum is not part of the Annual Maximum Dental Benefit. See Attachment A for orthodontia code details.

Optional Services

Optional Services are those that cost more than the standard form of treatment covered under CHIP. Your dentist must tell you if a service is optional. If you choose to receive these services, you must pay for the cost of the service above the standard covered cost.

Notice of Privacy Practices

How do we protect your privacy?

We strive to protect the privacy of your Personal Health Information (PHI) in the following ways:

- We have strict policies and rules to protect PHI
- We only use or give out your PHI with your consent
- We only give out PHI without your approval when allowed by law
- We protect PHI by limiting access to this information to those who need it to do given tasks and through physical safeguards

You have the right to look at your PHI.

How do I find out more about privacy practices?

Contact Member Services if you have questions about the privacy of your dental records. They can help with privacy concerns you may have about your dental information. They can also help you fill out the forms you need to use your privacy rights.

The complete notice of privacy practices is available at **https://www.guardianlife.com/privacy-policy.** You can also ask for a hard copy of this information by contacting member services at (877) 854-4242.

ATTENTION: If you need help in your language call 1-877-854-4242 (TTY: 1-888-346-3162). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-877-854-4242 (TTY: 1-888-346-3162). These services are free of charge.

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-877-854-4242 (TTY: 1-888-346-3162) También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-877-854-4242 (TTY: 1-888-346-3162). Estos servicios son gratuitos.

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

Definitions

Words to know:

Abuse is when a person does something that costs the CHIP program extra money. An example of provider abuse is when a dental provider gives more services than the patient needs. An example of client abuse is when a person goes to the emergency room when it isn't really an emergency.

Advanced Directives are legal written instructions from you to let others know the health care that you want to receive if you get very sick and can't decide for yourself.

Adverse Benefit Determination: May be any of the following:

1. the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of Covered Service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service;
4. the failure to provide services in a timely manner, as defined as failure to meet performance standards for appointment waiting times;
5. the failure of the Contractor to act within the time frames established for resolution and notification of Grievances and Appeals; or
6. the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Appeal: A review of an Adverse Benefit Determination taken by Premier Access.

Applicable: Applies to or refers to having an effect on someone or something.

Authorization: See Prior Authorization.

Balance Billing: Billing a patient for the difference between the dentist's actual charge and the amount paid by Premier Access.

Benefits: Medically necessary (needed) dental services provided by a Plan dentist that are available through the CHIP program.

Benefit Period is the 12-month period that begins with your first month of eligibility.

Caries: Another term for tooth decay or cavities.

Carved Out Services are CHIP covered services that are not paid for by us. You must get all covered dental services through us. Medical and mental health services are carved out and paid for by your health plan.

CHIP means the Children's Health Insurance Program

CHIP Eligible Individual means any person who has been certified by the Utah Department of Workforce Services to be eligible for CHIP benefits.

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Copayment is an amount you may have to pay for part of the costs for some services.

Covered Services: The set of dental procedures that are benefits of Premier Access. Premier Access will only pay for the medically necessary services provided a Premier Access dentist that are benefits of the CHIP program.

Durable Medical Equipment (DME) means equipment and supplies that are used every day and for a long time. DME is ordered by a doctor. Examples of DME are oxygen tanks, wheelchairs, crutches, and blood testing supplies. DME is sometimes called a Medical Supply.

Dental Specialist: A dentist providing specialty care such as endodontics, oral surgery, pediatric dentistry, periodontics, and orthodontics (braces).

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT): A federal program that provides health care for children through periodic screenings, diagnostic and treatment services. Dental care is included in the EPSDT program.

Emergency Care: A dental examination and/or evaluation by a Premier Access dentist or dental specialist to determine if an emergency dental condition exists, and to provide care to treat any emergency symptoms within the capability of the facility and within professionally recognized standards of care.

Emergency Dental Condition: A dental condition that in the absence of immediate attention could reasonably be expected to result in placing the individual's health in jeopardy, causing severe pain or impairing function.

Emergency Medical Condition is an illness, injury, symptom or condition that comes on suddenly. There is often pain or other symptoms. It could cause permanent harm or death if you don't get care right away.

Emergency Medical Transportation is transportation in an ambulance if you have an Emergency Medical Condition.

Emergency Room Care means services given in an emergency room when you have an Emergency Medical Condition.

Emergency Services are services needed to treat an Emergency Medical Condition.

Endodontist: A dental specialist who limits his or her practice to treat disease and injuries of the pulp and root of the tooth.

Enrollee means any CHIP Eligible Individual whose is enrolled in a CHIP health or dental plan.

Exclusion: Refers to any dental procedure or service not available under the CHIP program.

Fraud is when a person knows they did something wrong in order to get something he or she shouldn't get. An example of provider fraud is when a dentist bills for services that were not given to you or that you did not need. An example of client fraud is when a person tries to get dental care by using another person's CHIP card.

Grievance: A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination.

Habilitation Services are health care services that help you learn, keep, or improve skills for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities.

Habilitation Devices are medical tools and equipment to help you learn, keep, and improve your skills for daily living.

Health Insurance is a type of insurance that provides coverage for medical or dental care. Examples of medical care that health insurance might cover are visits to the doctor or emergency room, hospital stays, mental health care, dental services, vision services, etc.

Home Health Care is nursing care and home health services for people who can't go to a doctor's office. Examples of Home Health Care are physical and other therapies, nursing and care from a home health aide.

Hospice Services is special care for people who are near the end of their lives. This includes helping the patient feel comfortable and free from pain. Hospice Services is also emotional and spiritual care for patients and their families.

Hospital Inpatient Care (Hospitalization) is when a person is admitted to a hospital for treatment.

Hospital Outpatient Care means services you can get in a hospital or hospital clinic but when you don't stay overnight. Examples are minor surgeries or procedures, lab work or x-rays.

Limitations: Refers to the number of services allowed, type of service allowed, and/or the most affordable dentally appropriate service.

Medically Necessary: Covered services which are necessary and appropriate for the treatment of the teeth, gums, and supporting structures and that are (a) provided according to professionally recognized standards of practice; (b) determined by the treating dentist to be consistent with the dental condition; and (c) the most appropriate type and level of service considering the potential risks, benefits, and covered services which are alternatives.

Medically Necessary Services: Services or supplies that are proper and needed for the diagnosis or treatment of your dental or medical condition, are provided for the diagnosis, direct care, and treatment of your dental or medical condition, meet the standards of good dental or medical practice in the local area, are more effective, more conservative and/or less costly than other treatments available and aren't mainly for the convenience of you, your dentist or doctor.

Network: The dentist, hygienist, and dental specialists available within the Plan's service area that have agreements with the Plan to provide dental service to its members.

Network Provider is a doctor, dentist or other healthcare provider that is part of our Network.

Non-Covered Service: A dental procedure or service that is not a covered benefit.

Non-Emergency Medical Transportation is transportation for people who need a way to get to their medical appointment, but are not in an emergency situation.

Non-Participating Dentist: A dentist who is not authorized to provide services to CHIP eligible members.

Open Enrollment is the time when CHIP members can change from their current Plan to a different Plan. Open enrollment happens once every year.

Oral Surgeon: A dental specialist who limits his or her practice to the diagnosis and surgical treatment of diseases, injuries, deformities, defects and appearance of the mouth, jaws and face.

Orthodontist: A dental specialist who limits his or her practice to the prevention and treatment of problems in the way the upper and lower teeth fit together in biting or chewing.

Out-of-Network provider: A provider who is not part of the Premier Access network.

Out-of-Pocket Maximum is the most that you have to pay each year in co-payments.

Participating Dental Provider: A provider enrolled in the CHIP program that provides dental services to Premier Access members.

Pediatric Dentist: A dental specialist who limits his or her practice to treatment of children from birth through adolescence, providing primary and a full range of preventive care treatment.

Physician Services are services provided by someone who is licensed under state law to practice medicine.

Plan is a managed group of doctors, dentists, mental health providers, pharmacies, hospitals, medical suppliers, and other medical professionals who will provide your services. CHIP has the following types of Plans to provide covered services: health plans and dental plans.

Plan Year is the period between July 1st and June 30th every year.

Preauthorization is when a service has to be approved by us before you receive the service.

Premium is the quarterly amount that you may need to pay to be eligible for the CHIP program.

Preferred Drug List (PDL) is a list of common prescription drugs that are covered by your CHIP Plan.

Prescription Drug Coverage means certain generic and name-brand drugs that are covered by CHIP.

Prescription Drugs are generic and name-brand drugs that are prescribed by a doctor or dentist.

Primary Care Physician is a doctor who works with you and your Plan to make sure you get the care you need. A Primary Care Physician also helps you get care from specialists and other types of providers and hospitals. Examples of Primary Care Physicians are Family Practitioners, Internists, Pediatricians, Obstetrician/Gynecologist (OB/GYN), etc.

Primary Care Provider is the same as a Primary Care Physician except it includes other types of providers. Examples of other Primary Care Providers are Nurse Practitioners, Physician Assistants, Osteopaths, etc.

Primary Dental Provider is a dentist who works with you and your Plan to make sure you get the care you need. A Primary Care Dentist also helps you get care from specialists and other types of providers and hospitals.

Periodontist: A dental specialist who limits his or her practice to treatment of diseases of the gums and tissue around the teeth.

Prior Authorization: A request by a Premier Access dentist to approve services before they are performed. Dentist receive an authorization from Premier Access for approved services.

Prosthodontist: A dentals specialist who limits his or her practice to the replacement of missing teeth with dentures, bridges or other substitutes.

Provider is any organization, institution, or individual that provides health, or dental services and is part of your Plan's network.

Provider Directory: a list of all providers in the Premier Access network.

Rehabilitation Services are health care services that help you keep, get back, or improve skills for daily living that have been lost or damaged because you were sick or hurt.

Rehabilitation Devices are medical equipment and supplies that help you recover after being sick or hurt.

Requirements: Refers to something that you must do or riles you must follow.

Responsibility: Refers to something that you should do or are expected to do.

Skilled Nursing Care means nursing services that can only be done safely and correctly by a registered nurse or a licensed practical nurse.

Specialists are dentists who provide care for more complex problems. Some examples of specialists include orthodontists, oral surgeons, endodontists (dentists who perform root canals), periodontists (dentists who treat the gums), etc.

Urgent Care is care you need for serious dental problems usually within 24 hours. It is for problems that do not need to be treated in the emergency room because they will not cause permanent harm or death.

Waste is when money spent for dental care is not needed to provide the right kind of care. Waste is also when includes doing more than what is needed. An example of provider waste is when a dentist orders more tests than are needed to determine what is wrong with a patient. An example of member waste is when a member goes to more dental providers than needed.

Attachment A – Limitations and Exclusions

Practice Guidelines

Note: This section has many clinical terms. Your dentist can explain the terms in more detail. Your dentist can also answer questions you may have about this section. Prior-authorization may be required for some services. Co-pays vary depending on the service and your plan type.

Limitations

Preventive Service limitations:

- Oral exams limited to two per plan year.
- Cleanings limited to two per plan year. Periodontal maintenance (covered under
- Basic Services) also applies toward the frequency limitation.
- Bitewing x-rays limited to one series of four films 2 times per plan year. (Isolated bitewing or periapical films are allowed on an emergency basis.)
- Full mouth x-rays and panoramic films limited to once every 5 years.
- Space maintainers limited to initial appliance only and enrollees under age 14.

Basic Service limitations:

Restorations

- Replacement of a filling in less than 24 months from the date of first placement is not covered, unless due to specific health reasons.

Oral Surgery

- Surgical removal of impacted teeth is a covered benefit only when there is evidence of pathology.
- Under oral surgery, general anesthesia and intravenous sedation are covered only for the removal of impacted teeth and some other oral surgeries. General anesthesia and intravenous sedation and not covered with simple extractions.

Endodontics

Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- Under endodontics, general anesthesia and intravenous sedation are covered only for certain apicoectomy/periradicular surgery procedures.

Periodontics

- Periodontal maintenance is limited to 2 per plan year, following active periodontal therapy. Cleanings (covered under Preventive services) also apply toward the frequency limitation.
- Periodontal scaling and root planning, and subgingival curettage are limited to one treatment per quadrant in any 24 consecutive months.
- For periodontics, general anesthesia and intravenous sedation are covered only when provided in conjunction with certain osseous surgery procedures.

Other Basic Services

- Sealants are limited to permanent molars, with no decay, without restorations, limited to 1 time per 24-month period. Limited to enrollees through age 15.
- Sealant benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.
- Stainless steel crowns are limited to primary teeth. Only acrylic crowns and stainless-steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- Services for behavior management, other than oral sedation, provided in the dental office are not covered.
- Lab fees for denture repairs are not covered.

Major Service Limitations

Crowns

- Replacement of each crown is limited to once every 24 months.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling.
- Charges for lab fees for higher metals (noble, high noble) or porcelain are not covered. An allowance will be made for a full cast crown. Enrollee will be responsible for the difference.
- Implants, their removal or other associated procedures are not covered.

Fixed Bridges

- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment and will not be covered. If performed on an enrollee under the age of 16, the enrollee must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic and are not covered.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch and are not covered.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

Call Customer Service at 877-854-4242 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 5:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at https://portal.premierlife.com.

Removable Prosthetics (Dentures)

- Partial dentures will not be replaced within five years unless:
    1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
    2. The denture is unsatisfactory and cannot be made satisfactory.
- A removable partial denture is considered adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional and will be limited to the cost of a partial.
- Full upper and/or lower dentures are not to be replaced within five years unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one per arch in any six consecutive months.
- Tissue conditioning is limited to two per denture.
- Charges for actual lab fees for full maxillary or mandibular dentures will be the enrollee's responsibility. The enrollee will be responsible for the co-pay for full maxillary or mandibular dentures plus any applicable lab fees.
- Charges for actual lab fees for partial upper or lower dentures, rebases or laboratory relines will be the enrollee's responsibility. The enrollee will be responsible for the co-pay plus any applicable lab fees.
- Implants, their removal or other associated procedures are not covered.

Orthodontic Limitations

Premier Access will pay a portion of the initial banding costs and ongoing maintenance costs, up to the lifetime maximum of $1000.

- For American Indian/Alaska Native CHIP members, Premier Access will pay 100% of the upfront costs (initial banding) and 100% of ongoing treatment costs (monthly, quarterly, etc.) until the lifetime maximum of $1000 is reached. Member pays the remaining portion of the CHIP allowed fee after plan has paid the maximum annual benefit.
- For CHIP B members, Premier Access will pay 95% of the upfront costs (initial banding) and 95% of ongoing treatment costs (monthly, quarterly, etc.) until the lifetime maximum of $1000 is reached. Member pays the remaining portion of the CHIP allowed fee after plan has paid the maximum annual benefit.
- For CHIP C members, Premier Access will pay 50% of the upfront costs (initial banding) and 50% of ongoing treatment costs (monthly, quarterly, etc.) until the lifetime maximum of $1000 is reached. Member pays the remaining portion of the CHIP allowed fee after plan has paid the maximum annual benefit.
- Benefits limited to medically necessary orthodontic services. A medically necessary service is one needed to treat certain medical conditions. Enrollee must score a minimum of 30 on the Salzmann Index.
- Cephalometric x-ray limited to once in any 2-year period.
- Orthodontic treatment diagnostic casts (study models), limited to once per lifetime.

- Benefits for ongoing treatment are payable over the shorter of the treatment length or 24 months.
- Benefits are not paid to repair or replace any orthodontic appliance provided under CHIP.
- Benefits end immediately if treatment stops, or if the enrollee's CHIP coverage is terminated.
- If the enrollee's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the enrollee no longer qualifies for continued orthodontic treatment.
- If the enrollee's coverage ends after the start of treatment, the enrollee will be responsible for any additional charges for remaining treatment after coverage ends. The provider will not charge the enrollee more than the contracted rate for treatment remaining after the loss of coverage.

Dental Exclusions

- Services and supplies not listed in the scope of coverage, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
- Charges for cosmetic procedures and procedures performed primarily for cosmetic reasons.
- Charges for services related to, performed in conjunction with, or resulting from a non-covered service.
- Charges for services that are applied toward the satisfaction of deductible, if any.
- Charges for implants, myofunctional therapy, athletic mouth guards, precision or semi-precision attachments, treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis, orthognathic surgery or TMJ dysfunction.
- Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and anodontia.
- Charges for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.
- Charges for treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to equilibration, periodontal splinting or occlusal adjustment.
- Charges for extraoral grafts.
- Charges for treatment performed by someone other than a dentist or a person who by law may work under a dentist's direct supervision.
- Charges for services or supplies covered by any other health plan, medical expense, auto or no-fault plan.
- Charges for treatment performed by a person who ordinarily resides in the enrollee's household or who is related to the enrollee by blood, marriage or legal adoption.
- Charges for anesthesia, other than general anesthesia and IV sedation in connection with covered oral surgery or select endodontic and periodontal surgical procedures.
- Charges for local anesthesia. These charges are included within the cost of the procedures performed and cannot be charged separately.
- Charges for oral sedation and nitrous oxide.

General Exclusions

- Charges in excess of the contracted fee-for service schedule or the Reasonable and Customary Rate, whichever applies.
- Charges for any treatment program which began prior to the date the insured is covered by CHIP and Premier Access.
- Treatment of condition, injury or illness covered under any Workers'
- Compensation Act or similar law.
- Charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged for treatment in any such facility.
- Charges for drugs or the dispensing of drugs.
- Charges for oral hygiene instruction, plaque control, acid etch, prescription or take-home fluoride, dietary instruction, x-ray duplications, cancer screening, broken appointments, completion of a claim form, OSHA/ sterilization fees (Occupational Safety & Health Agency), or diagnostic photographs (except for orthodontic purposes).
- Services incurred during travel or activity outside of the United States, except for covered emergency services

Attachment B – Grievance and Appeal Form

Grievance/Appeal Form

Refer to page two of this form for information about grievances and appeals. If you need help with this form, please call us.

Mail completed form to:

Premier Access
Attn: Grievances/Appeals Dept., P.O. Box 38300
Phoenix, AZ 85069

The form can also be emailed to **AG@avesis.com** or faxed to 1-855-691-3243.

Customer Service:

Monday through Friday, 8:00 a.m. to 6:00 p.m.
Utah Medicaid: 877-541-5415
Utah CHIP: 877-854-4242

What program is this grievance/appeal request for?	☐ Utah Medicaid	☐ Utah CHIP
Who is completing this form? Providers can file a grievance/appeal on behalf of a member, with the member's written consent, which must be attached.	☐ Member	☐ Provider
Is a quick decision needed? A quick decision is needed when there is possible harm to a member's life, health, or ability to function. These are expedited appeals. Expedited appeals can be filed by calling Customer Service. A form is not needed.	☐ Yes	☐ No
Has this already been filed by phone? When you file an appeal by phone, a written form is not required. If you filed by phone and need to submit additional documents, please submit a completed form with your documents.	☐ Yes	☐ No
Do you want to continue receiving services while we process your grievance/appeal? If the member continues services while we process the grievance/appeal and the outcome is not in the member's favor, the member will be responsible for the cost of the disputed services received.	☐ Yes ☐ Does not apply	☐ No

Member ID Number:_____ Member Birthdate:_____ Telephone:_____

Member Last Name:_____ Member First Name:_____ MI: _____

Street Address:_____ City:_____ State:_____ ZIP:_____

Office Name:_____ Office Address:_____

Provider Name:_____Office Phone Number:_____

Contact/Person filing on the member's behalf (If applicable): _____

Contact Phone Number:_____

Describe the details of your grievance/appeal. Please provide specific information such as the date(s) of service, services involved, etc. Please use additional sheets if needed.

_____

_____

_____

_____

_____

Signature:_____Date:_____

Guidelines for Grievances and Appeals:

	Grievances	Appeals
What is it?	A grievance is a complaint about the way your dental care services were handled by your dentist or Premier Access.	An appeal is a request for Premier Access to review one of the following: • Request for services is denied or the approved services are less than what was requested • Previously authorized service is terminated, reduced, or suspended • Payment for a service is denied in whole or in part, and the denial could result in the member being liable for payment • A Premier Access network provider fails to provide services in a timely manner (e.g., appointment wait time requirement not met) • Premier Access failed to meet the timeframes for the Grievance and Appeals process.

What is an expedited request?	Not applicable for grievances.	An expedited appeal is a request for a quick decision. This is done to avoid possible harm to a member's life, health, or ability to function.
Who can file?	The member or provider.	The member, member's legally authorized representative, or a provider (on behalf of the member with the member's written consent).
How do I file?	A grievance can be filed orally or in writing.	An appeal can be filed orally or in writing. Written appeals can be submitted via mail, email, or fax. If submitting supporting documents, a written appeal is recommended. Call customer service to file an oral appeal.
When can I file?	A grievance can be filed at any time.	An appeal must be filed within 60 calendar days from the date of the Notice of Action. For services previously approved: If the original approval has not expired and the member wants to continue services while the appeal is processed, an appeal must be filed the later of the following: • By the intended effective date of the Action • Within 10 days of the Notice of Action
Can I receive services while my request is reviewed?	Not applicable for grievances	Disputed services can continue while the appeal is in process if all of the following apply: • The member requests to continue services • The appeal for the termination, suspension or reduction of a previously approved service • The original approval has not expired • The appeal was requested on time
How long does it take to process?	The grievance process takes up to 90 calendar days. A notice is sent with the decision.*	The appeal process takes up to 30 calendar days. A notice is sent with the decision. Quick or expedited appeals take up to three working days to process. You will receive notice of the decision.*

*Premier may take an additional 14 days for processing if either the member requests an extension, or there is a need for more information and it is in the best interest of the member. You will receive a notice of the reason for delay.

Fax: 855-691-3243
Email: **AG@avesis.com**

Attn: Grievances/Appeals Dept.
Premier Access
P. O. Box 38300
Phoenix, AZ 85069-8300
portal.premierlife.com

Attachment C – Privacy Policy

Customer Privacy Notice and our promise to you

At Guardian, we value every aspect of our relationship with you, and nothing is more important to that relationship than maintaining your trust and confidence. We take our responsibility to protect your personal information very seriously. The purpose of this notice is to make you aware of our policies and procedures for collecting, disclosing, and safeguarding the information that our current and former customers provide to us.

The Guardian Corporate Families include:

- The Guardian Life Insurance Company of America
- Berkshire Life Insurance Company of America
- The Guardian Insurance & Annuity Company, Inc.
- Sentinel American Life Insurance Company
- Family Service Life Insurance Company
- Managed DentalGuard, Inc.
- Avēsis Insurance Incorporated
- Managed Dental Care, Inc.
- Park Avenue Life Insurance Company
- IA PA, LLC (d/b/a IA PA Insurance Services in California)
- First Commonwealth, Inc. Innovative Underwriters, Inc.
- Premier Access Insurance Company
- Access Dental Plan
- DTC GLIC, LLC (d/b/a DTC GLIC Insurance Sales, LLC in California)

Collection of personal information

We collect the personal information of our customers from all of the following sources:

- Applications or other forms (such as policies) where we ask for items like your name, address, date of birth, etc.
- Your transactions with us and our affiliates (such as premium payments)
- Consumer reporting agencies and other similar sources relating to creditworthiness
- Our websites, where we capture information when you fill out forms

Disclosure of certain information

The law provides for the disclosure of certain information we collect as follows:

- With our affiliates – to administer your policy or account, or to give you information about other products and services that may be of interest to you. We may also share non-credit-related information with affiliates to develop marketing programs. We're allowed to do this without obtaining prior authorization, and the law does not allow customers to restrict these disclosures.
- We may also share with our affiliates your information about transactions and experiences with us (such as payment history).
- With your agent, broker, or representative – to service your policy or account.
- With non-affiliates – to administer your policy or account or to administer our business.
- With non-affiliates with whom we have a joint marketing agreement (such as other financial companies) – to send you information about products and services.

- We require all non-affiliates to keep your information confidential. We don't share your information with non-affiliates for any reason other than those above.
- With your authorization, information relating to your eligibility for insurance, including your creditworthiness, may be shared with our affiliates. You can limit this sharing by going to **guardianlife.com/privacy-policy** and clicking on Limit sharing of my information.

Note: We may also share your information if the law permits or requires sharing (for example, during the investigations of public authorities).

IMPORTANT: Why are you receiving this notice?

We're required by federal law to provide this notice when we start our relationship with you. You'll also receive it annually so long as you have a policy, contract, or other type of account with one or more of the entities listed in the Guardian Corporate Family. This requirement applies regardless whether we share any of your information.

Confidentiality and security

Under federal law, certain disclosures may require us to allow you to "opt-out" (i.e., allow you the option to not allow certain types of information sharing). If we're considering a disclosure that would trigger your right to opt-out, we'll let you do it before your information is shared. Any health information collected by us requires you to complete a separate authorization. We won't disclose your health information to anyone without your authorization, unless the law permits or requires us to. Access to your personal information is restricted to only those Guardian employees who need it to service your policy or account. We have physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to keep your personal information safe. If you decide to end your relationship with a member of the Guardian Corporate Family, or if your policy or account becomes inactive for some other reason, we'll continue to treat and safeguard your information as described in this notice. The accuracy of your information is important to us. You have the right to access and to seek correction of your information. You also have the right to request a record of any subsequent disclosures of your information. Contact us at the address below to receive more information regarding these rights or to receive a more detailed explanation of our privacy policies.

Visit us at **guardianlife.com/privacy-policy** to access Guardian's HIPAA Privacy Policy (paper copies are available upon request). If you're a Group planholder, please share this information with your plan participants.

The Guardian Life Insurance Company of America
Attn: Privacy Office, 10 Hudson Yards, New York, NY 10001
guardianlife.com

015258 (04-2021)

Attachment D – Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 05/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Website at **www.guardianlife.com/privacy-policy.**

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating

purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures.

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.

- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI may require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Accounting of Disclosure requests is available at **www.guardianlife.com/privacy-policy.**

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

Your Right to Amend Your PHI. If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All

others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention: Guardian Corporate Privacy Officer

Address: The Guardian Life Insurance Company of America
Group Quality Assurance – Northeast
P.O. Box 981573
El Paso, TX 79998-1573