PREMIER ACCESS

Member Handbook

What you need to know about your Benefits

Premier Access Insurance Company

Combined Evidence of Coverage and Disclosure Form

Utah Children's Health Insurance Program (CHIP)

Updated 12/2020

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. 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.

English ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-854-4242 (TTY: 1-888-346-3162).	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-854-4242 (TTY: 1-888-346-3162).
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1-877-854-4242（TTY：1-888-346-3162）。	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-854-4242 (TTY: 1-888-346-3162).
Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-854-4242 (TTY: 1-888-346-3162)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 1-877-854-4242 (TTY: 1-888-346-3162).
Farsi **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-854-4242 (TTY: 1-888-346-3162) 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 1-877-854-4242 (TTY: 1-888-346-3162).	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-854-4242 (TTY: 1-800-735-2929).
French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-854-4242 (ATS : 1-888-346-3162)	**Italian** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-854-4242 (TTY: 1-888-346-3162).
Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-854-4242 (телетайп: 1-888-346-3162).	**Armenian** ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-854-4242 (TTY (հեռատիպ)՝ 1-888-346-3162):
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-854-4242 (TTY: 1-888-346-3162).	**Portuguese** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-854-4242 (TTY: 1-888-346-3162).

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.

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 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. The call is free.

Thank you,

Premier Access Insurance Company
8890 Cal Center Dr.
Sacramento, CA 95826

Contents

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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 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.

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 feel more comfortable speaking 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 your preferred written language by calling our Member Services team.

Rights and Responsibilities

What are my rights?

You have the right to:

- Communicate openly and freely with Premier Access and their dentists and other oral health providers without fear of retribution
- Expect privacy according to HIPAA (Health Insurance Portability and Accountability Act) and other state or federal guidelines
- Be treated with respect, courtesy, and dignity and privacy
- Be treated the same as all other patients
- Be treated without discrimination based on race, religion, color, sex, national origin, or disability
- Be informed of your oral health status and examination findings
- Participate in choosing treatment options
- Receive information on treatment options in a manner that you can understand, including receiving materials translated into your primary language, upon request
- Know whether treatment is medically necessary
- Know whether the treatment is experimental and give your consent

- Refuse any treatment, except as provided by law
- Be provided with a phone number in case of an emergency
- Obtain non-covered services only when a disclosure form is signed by all parties
- Submit a complaint against a provider, without fear of retribution
- Be informed of any appeals filed on their behalf
- Change providers
- File grievance issues with Premier Access
- Access your records to review and/or change

What are my responsibilities?

Your responsibilities are to:

- Choose providers who participate in the Premier Access network
- Provide accurate information to the providers
- Understand the medicines you take and know what they are, what they are for, and how to take them properly, and to provide your doctor with a correct list of medications at each visit
- Provide complete information about past or present complaints/illnesses, hospitalizations, surgical procedures, and allergies
- Respect the rights, property, and environment of all providers, employees, and other patients
- Behave in a respectful manner and not be disruptive to the office
- Understand the status of your oral health
- Choose a mutually agreed upon treatment plan with options you believe are in the best interest of your oral health
- Ask about a fee associated with any non-covered service before the service is rendered
- Use best efforts to not miss or be late for an appointment
- Cancel scheduled appointment in advance, if unable to make it
- Provide emergency contact information
- Follow home care instructions
- Call the dentist of record in the event of an emergency
- Report suspected, fraud, waste, and abuse
- Follow the rules of your dental plan
- Read this Member Handbook
- Show your CHIP ID card each time you get dental care

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.

- Cancel dental appointments 24 hours ahead of time if needed
- Respect the staff and property at your provider's office
- Understand the dental care you need
- Tell us if you get an incorrect bill
- Pay your quarterly Premium

Contacting My CHIP Dental Plan

Who can I call when I need help?

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

We can help you:

- Find a dentist
- 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 on the internet at https://portal.premierlife.com.

CHIP Benefits

How do I use my CHIP benefits?

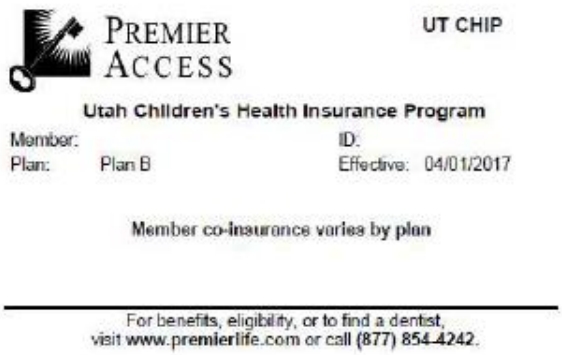
Each CHIP member will get a Utah CHIP dental ID card.

You should receive your ID within 21 days of being enrolled. You should show your CHIP dental ID card before you receive services or get a prescription filled. Always make sure that the provider accepts your CHIP dental plan, or you may be required to pay for the service.

A list of covered services is found on page 25.

What does my Utah CHIP dental ID card look like?

The Utah CHIP dental ID card is wallet-sized and will have the member's name, CHIP ID number and benefit plan. Your Premier Access Utah CHIP dental ID 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 to get a new card.

Can I view my CHIP benefits online?

You can check your CHIP coverage and plan information online at https://portal.premierlife.com.

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?

A Primary Dental Provider (PDP) can be a general dentist or a dentist who treats children. The PDP is the dentist who gives you or your child services that prevent or treat dental problems. Your PDP knows you and your 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.

How do I choose a Primary Dental Provider?

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.

You may choose any dentist who is on our network. 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 dentist?

You may call Member Services to change your PDP. We will be able to help you.

Cost Sharing

Cost sharing is the amount not covered by your insurance that you pay out of your own pocket. This includes deductibles, copayments, and coinsurance.

What are copayments?

A copayment (copay) is a portion of the cost that you have to pay for some services. Most CHIP families will need to pay a co-pay for medical and dental services. Your CHIP co-pay plan (B or C) is based on your income, and is determined by a representative from your local eligibility office. For additional copay information, refer to CHIP Copay Chart. The co-pay plan you are assigned will be listed on your CHIP ID card.

CHIP Copay Chart

BENEFITS (per planyear)	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
PREVENTIVESERVICES **- Routine exams** **- Cleanings (2 peryear)** **- Topical fluoride** **- X-rays**	$0	$0
BASIC SERVICES **- Fillings** **- Extractions** **- Oral surgery** **- Endodontics** **- Periodontics**	5% of approved amount	20% of approved amount after deductible
MAJORSERVICES **- Crowns** **- Bridges** **- Dentures**	5% of approved amount	50% of approved amount after deductible
ORTHODONTICS **- Requires prior authorization** **- covered only if medically necessary**	5% of approved amount ($1,000 lifetime maximum**) Requires prior authorization	50% of approved amount ($1,000 lifetime maximum**) Requires prior authorization
SPECIALISTS **- Endodontists** **- Oral Surgeons** **- Periodontists** **- PediatricSpecialists** **- 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.

** Orthodontic services are not included in the annual maximum benefit.

*** The Maximum Dental Benefit and Orthodontic Lifetime Maximum applies for all members, including American Indian/Alaska Natives.

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.

What is a Deductible?

A deductible is the part of a claims that is not covered by CHIP. Plan B and C require that you pay a deductible. You must pay the deductible first before your CHIP plan can pay the remaining cost of these bills. A deductible is a set amount each year and once that amount has been met, you no longer have a deductible for the remainder of the plan year. The plan year starts on July 1st and ends on June 30th every year.

What is a Premium?

Depending on your income, you may need to pay a premium every quarter. The premium is a set amount no matter how many children you have. The Department of Workforce Services (DWS) will send an invoice when your premiums are due.

What is Co-Insurance?

Some services have a co-insurance. A co-insurance is a percentage of the total bill that you are responsible to pay for. The co-insurance percentage can be different depending on the service however, it is usually 5-20% of the billed amount.

What is an Out-of-Pocket Maximum?

CHIP has a limit on how much you have to pay in cost sharing. You do not need to pay more than 5% of your household's countable income for out-of-pocket expenses each benefit period. The benefit period is the 12-month period that begins with your first month of eligibility. Out-of-Pocket expenses include deductibles, premiums, co-insurance, and copays.

Non-covered services do not count towards the Out-of-Pocket Maximum

What happens when I reach my Out-of-Pocket Maximum?

Once you reach your Out-of-Pocket Maximum, contact CHIP at 1-888-222-2542 and we will help you through the process.

Make sure you save your receipts every time you pay your copay. Once you have reached 5% of your household's annual income, your household will no longer have to pay copays for that benefit period.

Who does not have a Copay?

- Alaska Natives
- American Indians

What should I do if I receive a dental bill?

If you receive a bill for services that you believe should be covered by CHIP, call Member Services 877-854-4242 for assistance. Do not pay a bill until you talk to Member Services. You may not get refunded if you pay a bill on your own.

You may have to pay a dental bill if:

- You agree (in writing) to get specific care or a service not covered by CHIP before you get the service.
- 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).

Emergency Dental Care

What is a dental emergency?

A dental emergency is a condition that needs treatment right away. It includes treatment of an unforeseen, sudden, and acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.

What Should I do in a dental Emergency?

First, contact your dentist. Most offices have an emergency contact 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

What should I do after I get emergency care?

Call us as soon as you can after getting emergency care. Notify your Primary Dental Provider (PDP) to tell them about your emergency 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 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 21 days for routine, non-urgent appointments
- The same day for urgent care that can be treated in a dentist's office

Prior Authorization

What is prior authorization?

Some services must be approved by Premier Access before they will be paid. Permission to receive payment from Premier Access for that service is called prior authorization.

If you need a service that requires prior authorization, your dentist will request permission from Premier Access. If approval is not given for payment of 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, it must be approved by the Plan 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

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Time frames for processing prior authorizations are:

- Standard – 14 calendar days
- Expedited – 72 hours

Other Dental Insurance

What if I have other dental insurance?

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, etc.). You must notify the Department of Workforce Services (DWS) within ten (10) days of enrollment.

Once DWS is notified, they will review the information 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.

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:

- 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.

To find out more information on how to create one of the Advance Directives, please go to: https://portal.premierlife.com or call 877-854-4242.

Appeals, Grievances, and State Fair Hearings

What is an adverse benefit determination?

An adverse benefit determination is when we:

- Deny payment for care or approve payment for less care than you wanted.
- Lower the number of services you can get or end payment for a service that was approved.
- Deny payment for a covered service.
- Deny payment for a service that you may be responsible to pay for.
- Did not take action on an appeal or grievance in a timely manner.
- Did not provide you with a dental appointment in a timely manner; defined as 21 days for a routine dentist visit and same day for an urgent care visit.
- Deny an enrollee's request to dispute a financial liability.

You have a right to receive a notice of adverse benefit determination (sometimes called a notice of action) if one of the above occurs. If you did not receive one, contact member services to have one sent to you.

What is an appeal?

An appeal is when you or your provider contacts us to review an adverse benefit determination to see if the right decision was made.

How do I file an appeal?

- You, your provider or any authorized representative may file an appeal
- An appeal form can be found on our website at https://portal.premierlife.com and

in the back of this handbook in Attachment B.

- A request for an appeal will be accepted by mail

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

  Email: ag@avesis.com

  Telephone: (877) 854-4242

- Submit the appeal within 90 days from the notice of adverse benefit determination.
- Help will be provided to enrollees, upon request, in carrying out the required steps to file an appeal (e.g., interpreter services, TTY)
- 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. You will be notified in writing if more time is needed to make a decision on your appeal. If you or your provider think it's important to make a decision quickly, you can make a request for a quick appeal. A quick (expedited) appeal decision will be made within 72 hours.

What happens to your benefits while you appeal?

If you are appealing because a service you have been getting is limited or denied, tell us if you want to continue to get that service. You may have to pay for the service if the decision is not in your favor.

What is a quick appeal?

If waiting 30 days will harm your health, life or ability to maintain or regain maximum function, you can ask for a quick appeal. A quick appeal will be accepted over the phone or in writing. We will make a decision within 72 hours.

If we cannot do a quick appeal, we will send you a letter and explain why we cannot do a quick appeal.

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 is a grievance?

A grievance is a complaint about the way your dental care services were handled by your dentist or Premier Access.

How do you file a grievance?

If you are not happy with the way services were provided to you, you have the right to file a grievance. This gives you a chance to tell us about your concerns. You can file a grievance about issues related to your health care such as:

- When you don't agree with the amount of time that we need to make an authorization decision.
- Whether care or treatment is appropriate
- Access to care
- Quality of care or services
- Staff attitude
- Rudeness
- Any other kind of problem you may have had with your health care service

You can file a grievance 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

We will let you know of our decision about your grievance within 90 days from the day we get your grievance.

What is a State Fair Hearing?

A State Fair Hearing is a hearing you, your authorized representative, or your provider can request with the State Medicaid / CHIP Hearings Unit if you are unhappy with our decision about your appeal**.**

How do I request a State Fair Hearing?

If you or your provider are unhappy with an adverse benefit determination taken by Premier Access, you may file a hearing request with the Office of Administrative Hearings by calling 1-801-538-6576. The hearing request must be made within 120 calendar days of our appeal decision.

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 health care provider or a person getting CHIP is doing something wrong.

Some examples of fraud, waste and abuse are:

By a Member

- Lending a CHIP ID card to someone
- 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 ID 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

10324 S. Dolfield Rd.
Owings Mills, MD 21117

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.

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. Utah CHIP covers emergency medical transportation.

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

For Pregnant Members:

Pregnant members can get added services each plan year.

- One added oral exam and either one added routine cleaning or one added periodontal scaling and root planing per quadrant.
- The member must give the dentist written evidence that she is pregnant. This is sent in with the claim.

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

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

Non-Covered Services

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

- Non-emergency services received in the emergency room
- Non-emergency or non-urgent services from a non-network dentist (with no prior approval)
- Services done without required prior approval
- Services from a non-network dentist (except in cases listed under the "Choosing a Primary Care Dental Provider" section)
- Services received that are more than the limits in this book, that did not get approved.
- 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 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.

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.

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.

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.

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

- Composite, resin or white fillings on back teeth are considered optional services.
- 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 unit is limited to once every five years.
- 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.

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. For enrollees on Plan A or Plan B, Premier Access will pay 95% of the upfront costs (initial banding) and 95% of ongoing treatment costs (monthly, quarterly, etc.) until the lifetime maximum is reached. For enrollees on Plan C, Premier Access will pay 50% of

the upfront costs (initial banding) and 50% of ongoing treatment costs (monthly, quarterly, etc.) until the lifetime maximum is reached.

- 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 1 per person.
- 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 & Appeal Form

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.

Attachment C – Privacy Statement

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.

Attachment D – Notice of Privacy Practice

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.