CHIP

Children's Health Insurance Program

Premier Access Insurance Co.
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Utah Children's Health Insurance Program (CHIP) Enrollee Handbook

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Welcome to Premier Access

The Utah Children's Health Insurance Program (CHIP) covers children with no insurance. Premier Access Insurance Company (Premier Access) provides CHIP dental coverage. This book tells you about your plan. It lists who to call for help.

Customer Service

Customer Service can help you with questions about your plan. Examples of what they can help you with are listed below.

- How to get dental services.
- How to choose a dentist.
- How to make a complaint.
- Our company and our operations.
- How we choose dentists.
- Incentive plans we may offer dentists.
- Questions about this book.

Their number is **1-877-854-4242.** The hours are Monday through Friday from 8:00 am to 5:00 pm. **(TDD/TTY 1-888-346-3162)**

Rights and Responsibilities

You have the right to:

- Receive information about the plan.
- Be treated with respect.
- See a dentist in a reasonable time.
- Receive covered services from a dentist who is qualified.
- File a grievance or appeal.
- Change plans at open enrollment.
- Have your dental records kept private.
- Suggest changes to your rights and responsibilities.
- Receive information about treatment options.
- Make decisions about your treatment.
- Refuse any treatment.
- Not be restrained or secluded in order to:
  - force or convince you
  - punish or retaliate against you
  - make a situation easier for the plan or dentist

If you exercise these rights, it will not impact how you are treated by Premier or a provider.

Your responsibilities are to:

- Provide correct information to dentists and the Plan.
- Understand the dental care you need.
- Show your ID card at each appointment.
- Ask questions about dental conditions.
- Call your dentist if you are going to miss your appointment.
- Tell us if you get an incorrect bill.

CHIP Eligibility

Contact the Utah Department of Workforce Services if you have CHIP eligibility questions. The number is 1-866-435-7414.

Changing Dental Plans

You can change dental plans during open enrollment. You may be able to change outside of open enrollment. There must be a valid reason. Call the Utah Department of Health at 1-866-608-9422 for details.

Language Assistance

The Plan has free language services. We can arrange for someone to interpret or translate for you. You can get this service in-person and by phone. You can use this service to speak with us and your dentist. We can also provide materials in other formats, such as large print, Braille or audio. Call us at 1-877-854-4242 if you need this service.

You can get materials in Spanish. Call us at 1-877-854-4242 if you need Spanish materials.

Los materiales del miembro están disponibles en Español. Si Usted necesita materiales en Español, llame al Servicio al Cliente al 1-877-854-4242.

Coverage

This table is a list of the benefits for CHIP Members. Your ID card will let you know if you are on Plan B or C. The Coverage Limitations and Exclusions are listed in **Attachment A**.

Call Customer Service at 1-877-854-4242 if you have questions.

BENEFITS	MEMBER CO-PAY [1]	
	PLAN B	PLAN C
Deductibles – Per Plan Year	None	$50 per member $150 per family
Preventive Services: • Routine exams • Cleanings • Topical fluoride • X-rays • Space maintainers	$0	$0
Basic Services: • Sealants • Fillings • Oral surgery • General Anesthesia • IV Sedation • Endodontics • Periodontics • Stainless Steel Crowns • Denture Repairs • Emergency	5% of covered charges	20% of covered charges, after deductible
Major Services: • Crowns • Bridges • Dentures • Inlays • Onlays	5% of covered charges	50% of covered charges, after deductible
Maximum Dental Benefit [2]: • Preventive, basic, and major services per person per plan year • Orthodontic services are not included in the Maximum Dental Benefit	$1,000 per plan year	$1,000 per plan year
Orthodontics [2]: • Only covered if medically necessary • Needs prior approval • Lifetime Maximum: $1,000	5% of covered charges to Lifetime Maximum	50% of covered charges to Lifetime Maximum
Specialists: Endodontists, Oral Surgeons, Periodontists, Prosthodontists	5% of covered charges	Plan pays according to the dental plan's general dentist fee schedule and covered service category (Preventive, Basic, Major). Member is responsible for the difference between dental plan's payment and negotiated specialist fee.
Maximum Out-of-Pocket Expenses	5% of family's annual gross income (dental and medical expenses)	5% of family's annual gross income (dental and medical expenses)

[1] American Indian/Alaska Natives will not be charged co-pays, premiums, or a deductible.
[2] The Maximum Dental Benefit and Orthodontic Lifetime Maximum applies for all members, including American Indian/Alaska Natives.

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.

Using the Dental Plan

Member ID Card

You will get an Identification (ID) card.

- Show your ID card to your dental office.
- Call Customer Service if you need a card.
- No one else can use your card.

Choose a Primary Care Dentist

You can search for a dentist at www.premierlife.com or call us at 1-877-854-4242.

You must get care from a Dentist that is part of the **Premier Access** network. ***You must get approval from the Plan before you receive care from the dentist you choose who is not part of our network***.

You can go to a dentist who is not part of our network in these cases only:

- Indian Health Services
- Emergency Services
- Services approved by the Plan before you get care
- If there are no network Dentists within 40 miles of your home

Schedule an Appointment

It is very important to see a dentist and maintain good oral health! Make an appointment for your first visit today.

Once you choose a dentist:

- Call your Dentist when you need dental care.
- You should not have to wait longer than three weeks for routine care.
- If you will miss your appointment, call and schedule another time.
- The dentist will contact us about services that need approval.

Prior Approval for Certain Services

Certain services must be approved by Premier Access before you get treatment.

Your dentist will tell you if services must be approved. Your dentist must get approval before you get the services, or they may not be covered.

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.

Emergency Services and Urgent Care

An emergency is when:

- You think your life is in danger
- A body part is hurt badly
- You are in great pain.

You can get emergency services 24 hours a day, 7 days a week. You may get treated at the nearest dentist or emergency facility. ***You do not need prior approval for emergencies.***

Urgent problems usually need care within 24 hours. If you are not sure a problem is urgent call your dentist or urgent care clinic. You may also call us at 1-877-854-4242.

After you get emergency or urgent care, you must get all follow up care from your primary care dentist.

Payment for Emergency or Urgent Care Services

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 you for covered services. If you pay a bill, send a copy to us. The address is **Premier Access Insurance Company, Attn: Claims Department, P. O. Box 659010, Sacramento, CA 95865-9010.**

Deductible and Co-pays

On this plan you pay a deductible and co-pays. The "Coverage" section lists the amounts. You will pay this to your dentist when you get care.

Specialist Services under Plan C: You pay the cost between our cost and the specialist contracted fee for the covered service.

If you get a bill for a covered service, call us at 1-877-854-4242.

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 cost details.

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.

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 this service, you must pay for the cost of the service above the standard covered cost.

Out-of-Pocket Maximum

Your out-of-pocket maximum is for each benefit year or 12 months of CHIP coverage.

- It begins the month your child became eligible for CHIP.
- The maximum expense you will pay is 5% of your family's Annual Gross Income (AGI).
- If the out-of-pocket expense (medical and dental) is more than 5% of your family's AGI you should submit an out-of-pocket claim form
- Send the form to CHIP at P.O. Box 143108, Salt Lake City, UT 84114-3108

Once CHIP decides you have paid the 5% maximum, they will let us know. You will have no co-pay for the rest of the current benefit year (or until you reach the Annual Dental Benefit Max). You will get a new ID card that shows the $0 copay.

Grievances

A **grievance** is when you are not happy with a decision or action by the Plan or your dentist. You may have a grievance if you:

- could not find a dentist.
- could not get an appointment.
- had poor quality of care.
- were treated poorly by a dentist or staff member.
- have been discriminated against.

You can submit a grievance at any time. A grievance can be filed by you or your provider. To file a grievance, call us at 1-877-541-5415, or send a Grievance/Appeal Form:

Mail:	Premier Access Attn: Grievances/Appeals P.O. Box 255039 Sacramento, CA 95865-5039	**Fax:** **E-mail:**	1-916-646-9000, Attn: Grievances/Appeals GrievanceDept@PremierLife.com

Refer to Attachment B for a Grievance/Appeal Form. Call Customer Service at 1-877-854-4242 if you need help with the form. We will let you know that your grievance is in process within five days. We will send you a resolution letter within 45 days. In some cases, the time frame may be extended, either by your request or by Premier. If Premier extends it, you will receive a notice with the reason for the delay.

Appeals

An **appeal** is when you ask us to review our decision to deny or decrease a service. You have 30 days from the day you receive a denial to ask for an appeal.

You or a person who can legally represent you can file an appeal. A provider can also file an appeal for you, with your written consent. To file an appeal, send us a Grievance/Appeal form or call us at 1-877-854-4242. **Appeals filed by phone must be followed by a written, signed appeal letter or Grievance/Appeal form within five business days.** The date the appeal is filed by phone is considered the received date of the appeal.

Mail:	Premier Access Attn: Grievances/Appeals P.O. Box 255039 Sacramento, CA 95865-5039	**Fax:** **E-mail:**	1-916-646-9000, Attn: Grievances/Appeals GrievanceDept@PremierLife.com

In **Attachment B** of this handbook there is a Grievance/Appeal form. If you need help with the form, call us at 1-877-854-4242. We can help you with the form.

You can ask to continue your services while we process your appeal. If the appeal decision is not in your favor, you will have to pay for the treatment you receive.

We will notify you within 5 days that your appeal is in process. While it is in process, you can provide more information for Premier to review for your appeal. You can also ask to see all records we are using to make our decision.

We will send a letter with our decision within 30 days. If you ask for a faster decision due to your health, the decision will be expedited. Expedited appeals are done within 3 working days. This gives you less time to give us more information to review. The appeal time frame can be extended in some cases. If Premier extends the time frame, we will send you a notice with the reason for the delay.

You can ask for a State Fair Hearing if you are not happy with the decision. Call the Utah Department of Health at 1-801-538-6576.
At a State Fair Hearing, you may represent yourself, have another person represent you, or hire an attorney to represent you. A person representing a deceased member's estate can also be part of the State Fair Hearing.

ATTACHMENT A

Limitations and Exclusions

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

1. 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.
2. Charges for cosmetic procedures and procedures performed primarily for cosmetic reasons.
3. Charges for services related to, performed in conjunction with, or resulting from a non-covered service.
4. Charges for services that are applied toward the satisfaction of deductible, if any.
5. 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.
6. 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..
7. Charges for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.
8. 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.
9. Charges for extraoral grafts.
10. Charges for treatment performed by someone other than a dentist or a person who by law may work under a dentist's direct supervision.
11. Charges for services or supplies covered by any other health plan, medical expense, auto or no-fault plan.
12. 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.
13. Charges for anesthesia, other than general anesthesia and IV sedation in connection with covered oral surgery or select endodontic and periodontal surgical procedures.
14. Charges for local anesthesia. These charges are included within the cost of the procedures performed and cannot be charged separately.
15. Charges for oral sedation and nitrous oxide.

General Exclusions

1. Charges in excess of the contracted fee-for service schedule or the Reasonable and Customary Rate, whichever applies.
2. Charges for any treatment program which began prior to the date the insured is covered by CHIP and Premier Access.
3. Treatment of condition, injury or illness covered under any Workers' Compensation Act or similar law.
4. 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.
5. Charges by any hospital or other surgical or treatment facility and any additional fees charged for treatment in any such facility.
6. Charges for drugs or the dispensing of drugs.
7. 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).
8. Services incurred during travel or activity outside of the United States, except for covered emergency services.

Premier Access
Grievance/Appeal Form

ATTACHMENT B

Guidelines for Grievances and Appeals are provided on the back of this form.
If you need help filling out this form, please call Customer Service.
Customer Service hours are Monday through Friday from 8:00 am to 6:00 pm.

Utah Medicaid:	**1-877-541-5415**
Utah CHIP:	**1-877-854-4242**

Mail completed form to: Premier Access, Attn: Grievances/Appeals Dept., P.O. Box 255039, Sacramento, CA 95865-5039
The form can also be submitted via email: GrievanceDept@PremierLife.com.

What program is this grievance/appeal request for?	❑ Utah Medicaid ❑ Utah CHIP
Who is completing this form? *Providers can file an appeal on behalf of a member, with the member's written consent which must be attached.*	❑ Member ❑ Provider ❑ Member's legally authorized representative
Is an expedited decision needed? *An expedited case is when a quick decision is necessary to avoid possible harm to the member's life, health or ability to function. Expedited appeals can be filed by calling Customer Service, a form is not needed.*	❑ No ❑ Yes
Has this already been filed by phone? *Appeals filed by phone must be followed by a written appeal request within 5 working days (not required for expedited appeals).*	❑ No ❑ Yes
Do you want to continue receiving the disputed services while the appeal is processed? *If disputed services are continued while the appeal is being processed and the outcome of the appeal is not in favor of the Member, the Member will be responsible for the cost of the disputed services received.*	❑ No ❑ Yes ❑ Does not apply

Member Name: ______________________________

Client ID: ______________________ Telephone: ______________________

Address: ______________________________

City: ______________________ State: __________ ZIP Code: __________

Office Name: ______________________ Office ID: __________

Provider Name: ______________________ Provider ID: __________

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

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Guidelines for Grievances & Appeals

	Grievances	Appeals
What is it?	A grievance is dissatisfaction with any matter other than an Action.	A request for Premier to review an **Action** (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 network provider fails to provide services in a timely manner (i.e., appointment wait time requirement not met) • Premier failed to meet the timeframes for the Grievance and Appeals process.
What is an expedited request?	Not applicable for grievances.	An expedited appeal is when a decision needs to be made quickly. This is done to avoid possible harm to a member's life, health or ability to function.
Who can file?	Member or provider	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. Appeals filed orally must be followed with a written appeal within 5 business days. The appeal will not be processed if Premier does not receive a written appeal within 5 business days. *Written appeals not required for expedited appeals.*
When can I file?	A grievance can be filed at any time.	An appeal must be filed within 30 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: • within 10 days of the Notice of Action • by the intended effective date of the Action
Can I receive the services while my request is reviewed?	Not applicable for grievances.	Disputed services can continue while the appeal is in process if: • The member requests to continue services, • The appeal if for the termination, suspension or reduction of a previously approved service, • The original approval has not expired, and • The appeal was requested on time
How long does it take to process?	Decision notices are sent no later than 45 calendar days from the date Premier receives your grievance. Premier may extend the processing time by up to 14 additional days if: • The member requests an extension; or • Premier shows there is a need for more information and how it is in the best interest of the member. If it is extended, you will receive a notice with the reason for delay.	Decision notices are sent no later than 30 calendar days from the date Premier receives your appeal. For expedited appeals, you will receive a notice of the appeal decision within 3 working days from the day of your expedited appeal request. Premier may extend the processing time by up to 14 additional days if: • The member requests an extension; or • Premier shows there is a need for more information and how it is in the best interest of the member. If it is extended, you will receive a notice with the reason for the delay

Please call Customer Service if you need help with this form, have questions about the Grievance/Appeal process, or need an oral interpreter. Customer Service hours are Monday – Friday, 8am – 6pm.

CUSTOMER SERVICE

Utah Medicaid: 1-877-541-5415

Utah CHIP: 1-877-854-4242

ATTACHMENT C

PREMIER ACCESS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH 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 Premier Access Insurance 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.

Premier Access Insurance 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 Premier Access Insurance (using the information supplied below), or on our Web site at www.premierlife.com/wp-content/uploads/HIPAA-PrivacyNoticPremier.pdf

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 Premier Access Insurance Use and Disclose your Protected Health Information (PHI):

Premier Access Insurance 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.

Premier Access Insurance has the right to use or disclose your PHI for the following purposes:

Treatment. Premier Access Insurance 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. Premier Access Insurance 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. Premier Access Insurance 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. Premier Access Insurance may use and disclose your PHI to contact you and remind you of appointments.

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

Plan Sponsors. Premier Access Insurance 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.

Premier Access Insurance 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.

Premier Access Insurance is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Premier Access Insurance takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Premier Access Insurance 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.

Premier Access Insurance 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, Premier Access Insurance 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.premierlife.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 Premier Access Insurance or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Premier Access Insurance, 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 Premier Access Insurance in writing using the contact information listed below. For some requests, Premier Access Insurance 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.

Premier Access Insurance 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 Premier Access Insurance'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 Premier Access Insurance 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 Premier Access Insurance, 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. Premier Access Insurance reserves the right to deny your request if: (i) the PHI was not created by Premier Access Insurance, 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 Premier Access Insurance will review your request and the denial. The person conducting the review will not be the person who denied your request. Premier Access Insurance 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 Premier Access Insurance ID card. If you are a broker please call 888-326-3210. All others please contact us at 888-715-0760. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention: Premier Access Insurance Company
Privacy Officer

Address: The Premier Access Insurance Company
P.O. Box 659010
Sacramento, CA 95865-9010