Member Handbook

What you need to know about your Benefits

Premier Access Insurance Company

Combined Evidence of Coverage and Disclosure Form

Utah Medicaid

Updated 7/1/2019

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call 877-541-5415 (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 877-541-5415 (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 877-541-5415 (TTY 888-346-3162). The call is free.

English	Spanish
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 877-541-5415 (TTY: 888-346-3162).	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-541-5415 (TTY: 888-346-3162).
Chinese	**Vietnamese**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電877-541-5415（TTY：888-346-3162）。	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-541-5415 (TTY: 888-346-3162).
Korean	**Tagalog**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-541-5415 (TTY: 888-346-3162)번으로 전화해 주십시오.	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877-541-5415 (TTY: 888-346-3162).
Farsi	**Arabic**
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 888-346-3162) 877-541-5415 تماس بگیرید.	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	**Polish**
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 877-541-5415 (TTY: 888-346-3162).	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877-854-4242 (TTY: 800-735-2929).
French	**Italian**
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 877-541-5415 (ATS : 888-346-3162)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 877-541-5415 (TTY: 888-346-3162).
Russian	**Armenian**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877-541-5415 (телетайп: 888-346-3162).	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 877-541-5415 (TTY (հեռատիպ)՝ 888-346-3162):
German	**Portuguese**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 877-541-5415 (TTY: 888-346-3162).	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 877-541-5415 (TTY: 888-346-3162).

Call Customer Service at 877-541-5415 (TTY 888-346-3162). We're here Monday through Friday, from 8:00 a.m. to 6:00 p.m. The call is free. Or call the Utah Relay Line at 711. Visit us online at www.premierlife.com.

Welcome to Premier Access Utah Dental Medicaid!

Thank you for joining Premier Access Insurance Company (Premier Access). Premier Access is a dental plan for people who have Utah Medicaid. 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 877-541-5415 (TTY 888-346-3162) to ask for a copy of the Member Handbook at no cost to you or visit our website at www.premierlife.com to view the Member Handbook.

Contact us

We are here to help. If you have questions, call 877-541-5415 (TTY 888-346-3162). We are here from 8:00am to 6:00pm. The call is free.

Thank you,

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

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Premier Access Insurance Company

8890 Cal Center Dr.

Sacramento, CA 95826

www.premierlife.com

Customer Service: (877) 541-5415

TTY: (888) 346-3162

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)
- Provides 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 1-877-541-5415.

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

Jennifer Felice, Grievance and Appeals Department
P.O. Box 255039, Sacramento, CA 95865-5039
Toll Free: 1-888-346-3162 (TTY 1-888-346-3162) Fax: 1-916-646-9000
Grievancedept@premierlife.com

You can file a Grievance in person or by mail, fax, or email. If you need help filing a Grievance, Jennifer Felice, 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 http://www.hhs.gov/ocr/office/file/index.html.

Language Services

How can I get help in other languages?

Call Member Services at (877) 541-5415 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) 541-5415. 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 in the practice
- Be treated without discrimination based on race, religion, color, sex, national origin, or disability
- Be informed of their oral health status and examination findings
- Participate in choosing treatment options
- Receive information on treatment options in a manner that they can understand, including receiving materials translated into their primary language, upon request
- Know whether treatment is medically necessary
- Know whether the treatment is experimental and give his/her 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 their records to review and/or change

What are my responsibilities?

Your responsibilities are to:

- Follow the rules of your dental plan
- Read this Member Handbook
- Show your State Medicaid ID card each time you get dental care
- Cancel dental appointments 24 hours ahead of time if needed
- Respect the staff and property at your provider's office
- Use dentists and facilities in our network

Contacting My Medicaid 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) 541-5415 from Monday through Friday, from 8:00 AM to 6:00 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 www.premierlife.com.

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.

With an advance directive you can:

- Let your dentist know if you would or would not like to use life-support machines before something serious happens
- Let your dentist know if you would like to be an organ donor
- Decide right now what dental care you want or don't want
- Give someone the power to say "yes" or "no" to your dental treatments when you are no longer able

You may have a wish that a certain dentist or dental office cannot follow because of a moral or religious belief. If that happens the dentist or dental office should tell you so that you can decide if you want a different provider for your dental care.

If you have an advance directive and your doctor does not follow your wishes you can file a complaint with Grievance and Appeal Department.

You can let your dentist know about your feelings by completing a living will or power of attorney for dental care form. Contact your dentist for more information.

Medicaid Benefits

How do I use my Medicaid benefits?

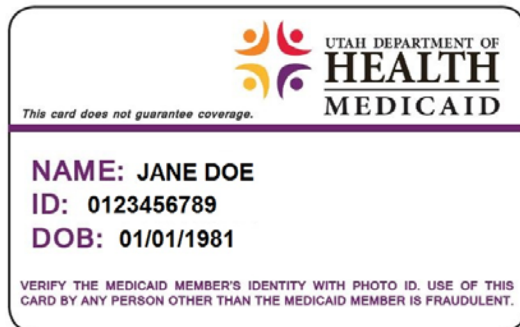
Each Medicaid member will get a Utah Medicaid card.

You will use this card whenever you are eligible for Medicaid. You should show your Medicaid card before you receive services or get a prescription filled. Always make sure that the provider accepts your Medicaid plan or you may be required to pay for the service.

A list of covered services is found on page 22.

What does my Utah Medicaid card look like?

The Utah Medicaid card is wallet-sized and will have the member's name, Medicaid ID number and date of birth. Your Utah Medicaid 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 the Department of Workforce Services (DWS) at 1-866-435-7414 to get a new card.

Can I view my Medicaid benefits online?

You can check your Medicaid coverage and plan information online at mybenefits.utah.gov.

Primary individuals can view coverage and plan information for everyone on their case. Adults and children 18 and older can view their own coverage and plan information. Access may also be given to your medical representative.

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

You may also view your plan benefits online at www.premierlife.com.

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 dental home is recommended by the American Dental Association. A primary dentist or dental home should be made prior to your 12th birthday. You should get care no later than your 1st tooth or 1st birthday.

You may choose any dentist who is on our network. We refer to this as an open network. If you need help locating a dentist, please call Member Services. You do not need to notify the plan of your dentist choice.

Copayments

What are copayments?

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

There are no copayments for Medicaid covered dental services provided by us.

What should I do if I receive a dental bill?

If you receive a bill for services that you believe should be covered by your Medicaid dental plan, call Member Services 877-541-5415 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.

If you paid for covered services, you can submit your bill for reimbursement to:

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

You may have to pay a dental bill if:

- You agree (in writing) to get specific care or a service not covered by Medicaid before you get the service.
- You ask for and get services during an appeal or Medicaid State Fair Hearing and the decision is not in your favor.
- You do not show your Utah Medicaid Card before you get dental care.
- You are not eligible for Medicaid.
- You get care from a dentist who is not with your dental plan, or is not enrolled with Utah Medicaid (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 is a dental emergency?

Contact your dentist, call 911, or go to the closest emergency room. You do not have to get prior authorization for emergency care.

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?

There is no copay for dental emergency care.

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.

If you have trouble getting in to see a dental specialist when you need one, call us at (877) 541-5415 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) 541-5415 if you have any questions.

These dental services need prior authorization, even if you receive them from a provider in the Premier Access network:

- Crowns
- Full and partial dentures
- Deep cleanings (scaling and root planing)
- Orthodontics

Call Customer Service or check with your dentist for a complete list of services that require prior authorization.

Restriction Program

What does it mean to be in the Restriction Program?

If you are in the Restriction program, all medical services and prescriptions must be approved or coordinated by your assigned physician. If you are enrolled in the Restriction Program, and your dentist writes you a prescription, you must talk to the State Medicaid Restriction Program staff about which pharmacy to use. You can contact them by calling 801-538-9045 or toll-free 1-800-662-9651 (press #900).

Other Dental Insurance

What if I have other dental insurance?

Some members have other dental insurance in addition to Medicaid. Your other insurance is your primary insurance.

If you have other insurance, your primary insurance will pay first. Please bring all of your dental insurance cards with you to your dental visit.

Please tell your dental plan and your dentist if you have other dental insurance. You must also tell the Office of Recovery Services (ORS) about any other dental insurance you may have. Call ORS at 801-536-8798. This helps Medicaid and your providers know who should pay your bills. This information will not change the services you receive.

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 www.premierlife.com
- A request for an appeal will be accepted by mail

Mail: Premier Access
Attn: Grievances/Appeals
P.O. Box 255039
Sacramento, CA 95865-5039

Fax: (916) 646-9000

Telephone: (877) 541-5415

- Submit the appeal within 60 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 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) 541-5415 or write to us at:

Premier Access
Attn: Grievances/Appeals
P.O. Box 255039
Sacramento, CA 95865-5039

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 either over the phone or in writing. To file by phone, call Member Services at (877) 541-5415. To file a grievance in writing, please send your letter to:

Premier Access
Attn: Grievances/Appeals
P.O. Box 255039
Sacramento, CA 95865-5039

We will let you know of our decision about your grievance within 45 days from the day we get your grievance.

What is a State Fair Hearing?

A State Fair Hearing is a hearing with the State Medicaid Agency about your appeal. You, your authorized representative, or your provider, can ask for a State Fair Hearing. When we tell you about our decision on your appeal, we will also tell you how to request the State Fair Hearing if you do not agree with our decision. We will also give you the State Fair Hearing Request Form to send to Medicaid.

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. 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 Medicaid 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 Medicaid is doing something wrong.

Some examples of fraud, waste and abuse are:

By a Member

- Lending a Medicaid 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 Medicaid member for covered services
- Not reporting a patient's misuse of a Medicaid ID card

How can I report fraud, waste, and abuse?

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

- Internal ACO compliance
    - Premier Access Insurance Company
Fraud, Waste and Abuse
P.O. Box 659010
Sacramento, CA 95865-9010
    - 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.

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 Medicaid covers emergency medical transportation.

How do I get to the dentist when it's not an emergency and I can't drive?

Medicaid can help you get to the dentist when it is not an emergency. To get this kind of help you must:

- Have Traditional Medicaid on the date the transportation is needed
- Have a medical or dental reason for the transportation
- Call the Department of Work Force Services (DWS) 1-800-662-9651 to find out if you can get help with transportation

What type of transportation is covered under my Medicaid?

- **UTA Bus Pass, including Trax** (Front Runner and Express Bus Routes are not included): If you are able to ride a bus, call DWS to ask if your Medicaid program covers a bus pass. The pass will come in the mail. Show your Medicaid card and bus pass to the driver.
- **UTA Flex Trans:** Special bus services for Medicaid clients who live in Davis, Salt Lake, Utah and Weber Counties. You may use Flex Trans if:
    - You are not physically or mentally able to use a regular bus
    - You have filled out a UTA application form to let them know you have a disability that makes it so you cannot ride a regular bus. You can get the form by calling:
        - Salt Lake and Davis counties: (801) 287-7433
        - Davis, Weber and Box Elder counties 1-877-882-7272
    - You have been approved to use special bus services and have a Special Medical Transportation Card.
- **Dial-A-Ride:** Special bus service available for members who live in Iron County

- Call 435-865-4510

- **LogistiCare:** non-emergency door-to-door service for medical, including dental, appointments and urgent care. You may be eligible for LogistiCare if:
  - You have Traditional Medicaid
  - There is not a working vehicle in your household
  - Your physical or mental disabilities make it so you are not able to ride a UTA bus or Flex Trans
  - Your doctor has completed a LogistiCare form

When approved, you can arrange for this service by calling LogistiCare at1-855-563-4403. You must make reservations with LogistiCare three business days before your appointment. Urgent care does not require a three-day reservation. (LogistiCare will call your dentist to make sure the problem was urgent.) Eligible clients will be able to receive services from LogistiCare statewide.

Can I get help if I have to drive long distances?

- **Mileage Refund**: Talk to a DWS worker if you have questions about a mileage refund. You will only be refunded if there is NOT a cheaper way for you to get to your dentist.

  Families with a child should check with a DWS worker to see about mileage refund for CHEC well-child medical and dental visits.
- **Overnight Costs:** In some cases, when overnight stays are needed to get medical treatment, Medicaid may pay for overnight costs. The cost includes lodging and food. Overnight costs are rarely paid in advance. Contact a DWS worker to find out what overnight costs may be covered by your Medicaid program.

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

Dental services covered by Premier Access

- 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

Services Covered by Medicaid but Not by a Dental Plan

The services listed below may be covered by either another type of managed care plan or by Medicaid fee-for service. The other types of managed care plans are mental health plans and physical health plans.

- Medical doctor visits
- Inpatient hospital care
- Mental health care
- Pharmacy
- Family planning
- Transportation (emergency and non-emergency)
- Vision care
- Physical and occupational therapy
- Medical supplies
- Podiatry
- Speech and hearing
- Chiropractic care
- Lab and x-ray services not related to dental care
- Home health
- Nursing home
- Hospice

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

Generally, Medicaid does not pay for non-covered services. However, there are some exceptions as listed below:

- Members who qualify for CHEC/EPSDT may obtain services which are medically necessary but are not typically covered
- Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery
- Reconstructive procedures to correct serious functional impairments (for example, inability to swallow)
- When performing the procedure is more cost-effective for the Medicaid program than other alternatives

If you would like to request an exception for a non-covered service, you can make that request by filing a grievance. You can file a grievance either over the phone or in writing. To file by phone, call Member Services at (877) 541-5415. To file a grievance in writing, please send your letter to:

Premier Access
Attn: Grievances/Appeals
P.O. Box 255039
Sacramento, CA 95865-5039

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) 541-5415.

Definitions

Words to know

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 Medicaid program.

Caries: Another term for tooth decay or cavities.

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 Medicaid program.

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.

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

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

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

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.

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

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

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.

Participating Dental Provider: A provider enrolled in the Medicaid 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.

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

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.

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.

Diagnostic and Preventive

- Oral exams are limited to 4 per calendar year for members age 20 and under. Limited to 2 per calendar year for members age 21 and over.
- Prophylaxis services (cleanings) are limited to 4 per calendar year for members age 15 and under. Limited to 2 per calendar year for members age 16 and over.
- Fluoride varnish applications are limited to 4 per calendar year.
- Panoramic films are limited to once every 2 years.
- Sealants on the permanent molars and pre-molars (bicuspids) covered for members age 20 and under, once every 2 years.

Endodontics

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

- Third molars are excluded
- Primary teeth excluded
- Therapeutic pulpotomy is covered for primary teeth only
- X-rays as part of a root canal procedure will be considered part of fee for the root canal
- Retreatment excluded Periodontics
- Gingivectomy for Members who use anticonvulsant medications
- Full mouth debridement available one time per year if subgingival calculus is present and may be billed in conjunction with a prophylaxis on the same date of service

Prosthodontics

- Full and Partial dentures will not be replaced within five years unless, it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible
- Hard relines that are completed by a laboratory are covered, two relines per calendar year, per arch
- Medicaid does NOT pay for temporary stayplate partials or temporary dentures.

Oral Surgery

- The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
- Under oral surgery, general anesthesia and non-intravenous sedation are covered only when provided in conjunction with removal of impacted teeth, and are not allowable in conjunction with simple extractions.

Orthodontic Services

Comprehensive treatment is only covered for orthodontic treatment. You MUST score thirty (30)

or more using the Salzmann's Index, the Handicapping Malocclusion Assessment Record.

Orthodontic benefits are provided only for children who have a handicapping malocclusion due to, birth defects, accidents, abnormal growth patterns of such severity that it renders them unable to:

- Masticate, digest, or benefit from their diet

Orthodontic benefits are provided for pregnant women who have a handicapping malocclusion as a result of a recent accident or disease, of such severity that they are unable to:

- Masticate, digest, or benefit from their diet

Orthodontic treatment must be provided by a network (contracted) provider. Treatment is deemed to start on the day the band of appliances are inserted or on the day that a one-step orthodontic procedure is performed.

<u>Orthodontic Benefits NOT covered:</u>

- Limited orthodontic and removable appliance therapies
- Removable appliances in conjunction with fixed banded treatment
- Habit control appliances
- Orthodontic services for cosmetic or esthetic reasons Combined Orthodontic/Surgical Treatment Cases
- Medicaid requires that a licensed orthodontic specialist and a licensed maxillofacial oral specialist be used to treat combined orthodontic/surgical cases.
- Services will not be covered if orthodontic/surgical treatment service is performed by a general dentist.

<u>Sedation Services</u>

- Sedation for anxiety is not covered nor does it qualify for a medical condition
- Behavior management is not covered
- Nitrous Oxide analgesia is not covered
- Oral sedation by prescription is only covered under the Medicaid pharmacy program
- General anesthesia for patients that meet age and/or other criteria
- For removal of erupted teeth, when medically necessary
- Performed by a dentist or oral surgeon possessing the proper Class IV permit under State Licensure

<u>Non-Covered Services</u>

Medicaid does NOT cover the following dental services:

1. Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth

2. Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex
3. Fixed bridges or pontics
4. Dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperisteal implants
5. Tooth transplantation
6. Ridge augmentation
7. Osteotomies
8. Vestibuloplasty
9. Alveoloplasty
10. Occlusal appliances, habit control appliances or interceptive orthodontic treatment
11. Treatment of temporomandibular joint syndrome or its prevention, sequel, subluxation, therapy, arthostomy, meniscectomy or condylectomy
12. House calls
13. Consultations and second opinions not requested by Medicaid
14. Processing claim forms
15. Charges for lab tests or pathology reports (the lab or pathologist must bill the charges directly to Medicaid)
16. General anesthesia for removal of an erupted tooth, unless medically necessary
17. Services which require preauthorization and are provided before the prior authorization is given. However, this exclusion does not apply to an emergency service.
18. Oral sedation and behavior management fees.
19. Temporary dentures or temporary stayplate partial dentures
20. Limited orthodontic treatment, including removable appliance therapies
21. Removable appliances in conjunction with fixed banded treatment
22. Habit control appliances
23. Incomplete Root Canal

Grievance/Appeal Form

Refer to the back of this form for information about grievance and appeals. If you need help with this form, please call us.

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

CUSTOMER SERVICE
Mon-Fri 8am to 6pm
Utah Medicaid: 1-877-541-5415
Utah CHIP: 1-877-854-4242

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 a quick decision needed? *A quick decision is needed when there is possible harm to a member's life, health or ability to function. These are "expedited appeals". Expedited appeals can be filed by calling Customer Service. A form is not needed.*	☐ No ☐ Yes
Has this already been filed by phone? *When you file an appeal by phone, you must also send a written appeal. Written appeals must be sent within 5 working days. It is NOT required for expedited appeals.*	☐ No ☐ Yes
Do you want to continue receiving services while we process your appeal? *If the member continues services while we process the appeal 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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Guardian

Privacy Policy

The Guardian Corporate Family includes:

- The Guardian Life Insurance Company of America
- Guardian Investor Services, LLC
- Park Avenue Life Insurance Company
- Premier Access Insurance Company
- Access Dental Plan
- Berkshire Life Insurance Company of America
- Hanover Acquisition LLC
- Family Service Life Insurance Company
- Managed DentalGuard, Inc.
- Avesis Insurance Incorporated
- The Guardian Insurance & Annuity Company, Inc.
- First Commonwealth, Inc
- Innovative Underwriters, Inc.
- Sentinel American Life Insurance Company

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

We collect the personal information of our customers from the following sources:
- Applications or other forms, such as policies, where we obtain items such as your name, date of birth, etc.;
- Your transactions with us and our affiliates, such as premium payments;
- Consumer reporting agencies and other similar sources relating to creditworthiness; and
- Our internet websites, where we capture items that you provide when you fill out forms.

To better serve you, the law provides for the disclosure of certain information we collect as follows:
- With affiliates to administer your policy or account, or to give you information about other products and services that may be of interest to you. We may also share non-credit-related information with affiliates to develop marketing programs. We may do this without obtaining prior authorization and the law does not allow customers to restrict these disclosures.
- We may also share your information with our affiliates about your transactions and experiences with us, such as payment history.
- With your agent, broker, or representative in order to service your policy or account.
- With non-affiliates in order to administer your policy or account or to administer our business.
- With non-affiliates with whom we have a joint marketing agreement, such as other financial companies, in order to send you information about products and services. We require all non-affiliates to keep your information confidential. We do not share your information with non-affiliates for any reason other than those stated above.

We may also share your information if the law permits or requires sharing, such as during the investigations of public authorities.

IMPORTANT: WHY YOU ARE RECEIVING THIS NOTICE

We are required by federal law to provide this notice upon the establishment of our relationship with you; furthermore, we must provide this notice annually so long as you have a policy, contract or other type of account with one or more of the entities listed in the Guardian Corporate Family. This requirement applies regardless of whether or not we share any of your information.

CONFIDENTIALITY AND SECURITY

Under federal law, certain disclosures may require us to allow you to "opt-out" (i.e. allow you the option to prohibit certain types of information sharing). If we are considering a disclosure that would trigger your right to opt-out, we will allow you to do so before your information is shared.

Any health information collected by us requires you to complete a separate authorization. We will not disclose your health information to anyone without your authorization, unless the law permits or requires us to do so.

Access to your personal information is restricted to only those Guardian employees who need it to perform the services required of your policy or account. We have physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to keep your personal information safe. If you decide to end your relationship with a member of the Guardian Corporate Family, or if your policy or account becomes inactive for some other reason, we will continue to treat and safeguard your information as described in this notice.

The accuracy of your information is important to us. You have the right to access and to seek correction of your information. You also have the right to request a record of any subsequent disclosures of your information. You may contact us at the address below to receive more information regarding these rights or to receive a more detailed explanation of our privacy policies.

Visit us at http://www.guardianlife.com/Privacy-Policy where Group planholders may also access Guardian's HIPAA Privacy Policy; paper copies are available upon request. We ask that Group planholders share this information with their plan participants.

The Guardian Life Insurance Company of America Attn: Privacy Office, 7 Hanover Square, H-23E, New York, NY 10276-0780 www.GuardianLife.com

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NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective: 05/01/2016

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

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

What is Protected Health Information (PHI):

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

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

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

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

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

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

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

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

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

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

Guardian is required to use or disclose your PHI:

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

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

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

Other Uses and Disclosures.

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

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention: Guardian Corporate Privacy Officer
National Operations

Address: The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457