GEHA
Connection
Dental Network.

Provider Manual

Important Credentialing Information and Rights for Participating Providers

Once you have been initially accepted in the GEHA/Connection Dental Network, you will be considered to be approved in the recredentialing process we perform every three years unless you are otherwise notified by us. You must continue to meet or exceed GEHA's credentialing criteria, applicable accreditation standards, and state requirements in order to remain in the network. Material adverse credentialing information received by the network will be considered by our Peer Review Committee and/or Dental Director in accordance with the GEHA/ Connection Dental Network Credentialing, Recredentialing and Quality Assurance Program Policies and Procedures.

You will be notified in writing of any change in your status of participation in our network unless you voluntarily terminate your participation, and you may have the right to appeal certain adverse changes in your status. Information regarding voluntary termination and network participation appeals rights is included in the GEHA/ Connection Dental Network General Policies & Procedures, Policy No. 1, Network Appeals/Disputes, which is included in this Provider Manual. GEHA has the right to determine the composition of its Connection Dental Network and any subset thereof.

You have the right to review credentialing information obtained from outside sources (e.g., malpractice insurance carriers and state licensing boards) that supports your credentialing application. GEHA/Connection Dental Network is not required to make available:

- References
- Recommendations
- Peer-review protected information
- Information prohibited by state or federal law to be disclosed
- The verification source used when credentials could not be obtained

You have the right to correct any missing, incorrect or conflicting credentialing information that we receive about you. If we determine there are variances in your information, we will notify you in writing within 30 days of our determination. You should respond as quickly as possible by email, facsimile or regular mail and send the information to the contact person identified in your letter, or you may call us with the information and we will document the call. You must respond to our request within your 180-day credentialing period unless a shorter timeframe is required by your state's laws. Any additional information you provide to us will be considered in your credentialing process and placed in your credentialing file.

Upon request, you have the right to be informed of the status of your credentialing application, and the network will provide the status to you within two (2) business days of your request. Your credentialing application may be in one of the following statuses:

- Received
- In Process
- Complete

You have the right to have your credentialing application processed in a non-discriminatory manner.

If a Participating Provider does not submit required recredentialing information within the 180-day recredentialing process deadline or if a Participating Provider does not submit information that is requested by the Peer Review Committee during an initial credentialing, recredentialing or quality assurance program review, the Participating Provider will be considered voluntarily terminated from the network and must reapply to join.

If you have questions or concerns about your credentialing rights, please contact us at:

GEHA/Connection Dental Network
Attn: Credentialing Department
20201 E. Jackson Drive
Independence, MO 64057
Phone 800.505.8880, option 3
Fax 816.257.4438

Important Credentialing Information
About Delegated Credentialing

If GEHA delegates the credentialing process to a third party entity ("Delegated Credentialing Entity"), the following provisions shall be deemed to be included in the Participating Provider Agreement:

Delegated Credentialing Entity Credentialing and Recredentialing.

1. By virtue of this Agreement and upon GEHA's review and approval of Delegated Credentialing Entity's credentialing procedures, and upon Delegated Credentialing Entity's agreement that it shall perform services in accordance with GEHA's credentialing requirements, GEHA delegates the credentialing function to Delegated Credentialing Entity for the Delegated Credentialing Entity Participating Providers, while retaining the ultimate credentialing decisions to GEHA. Delegated Credentialing Entity shall maintain current and complete credentialing files for each of the Participating Providers as required by the Delegated Credentialing Entity's approved credentialing procedures submitted to GEHA. As a condition of this Agreement, Delegated Credentialing Entity agrees to attach to the Participating Provider Agreement its credentialing procedures, including any agreements by which Delegated Credentialing Entity delegates all or part of its credentialing responsibility, and further including any and all revisions to such credentialing procedures upon occurrence. If Delegated Credentialing Entity further delegates all or part of the credentialing responsibility to another party after this Agreement is executed, Delegated Credentialing Entity shall notify GEHA in writing prior to such delegation, and such delegation shall be subject to the terms of this Agreement and in accordance with national accrediting standards that GEHA is required to meet.

2. Delegated Credentialing Entity agrees that for the term of this Agreement, all Participating Providers shall meet all requirements set forth in the Delegated Credentialing Entity's credentialing policies, as previously approved by GEHA. Upon request, Delegated Credentialing Entity agrees to confirm the credentialing status of a Participating Provider and provide to GEHA in a timely manner the information necessary for GEHA to make a decision regarding the network status of a Participating Provider. In the event a Participating Provider does not continue to meet the Delegated Credentialing Entity's credentialing policies, Delegated Credentialing Entity shall notify GEHA immediately upon becoming aware of such noncompliance. Such Participating Provider shall immediately cease rendering services to Covered Persons. Notwithstanding anything herein or any subsequently adopted procedure to the contrary, GEHA reserves the right to terminate, suspend, revoke, or reduce the membership or privileges of any Participating Provider as provided in the Credentialing and Recredentialing Policies and Procedures, and Delegated Credentialing Entity agrees to cooperate with GEHA to implement the foregoing.

3. Delegated Credentialing Entity shall promptly notify GEHA of any material change in the Delegated Credentialing Entity's ability to perform delegated credentialing, which may include loss or replacement of the senior clinical staff person or prolonged interruption of services due to any cause. Should the Delegated Credentialing Entity credentialing procedures approved by GEHA no longer conform with GEHA's credentialing requirements, GEHA may notify Delegated Credentialing Entity in writing of corrections to be made to Delegated Credentialing Entity's credentialing program to bring it into compliance within a specific period of time or GEHA may withdraw this delegation at any time upon advance written notice to Delegated Credentialing Entity. If Delegated Credentialing Entity does not make the requested corrections to its credentialing program within the specified timeframe or if GEHA withdraws its delegation, each Participating Provider will then be required to meet GEHA's Credentialing and Recredentialing Criteria in order to continue to participate under this Agreement.

4. GEHA is responsible for the oversight of its Delegated Credentialing Entities. As such, GEHA must ensure that Delegated Credentialing Entity is continuously in compliance with GEHA's credentialing requirements and may conduct surveys of the Delegated Credentialing Entity or require Delegated Credentialing Entity to submit periodic reports to GEHA regarding the performance of its delegated credentialing responsibilities. Except as required by applicable federal or state law, GEHA agrees to maintain in strict confidence all information it will review in the course of its onsite credentialing reviews, as listed below. Delegated Credentialing Entity agrees and shall cause its Participating Providers to agree to allow GEHA or its agents or designees access, at least every year and upon ten (10) business days' prior notice during normal business hours, to a random sample of complete credentialing files administered by Delegated Credentialing Entity on behalf of GEHA. The sample size will be ten percent (10%) of such files, but in no case less than ten (10) files or more than fifty (50) files. If fewer than 10 providers were credentialed or recredentialed since the last annual file audit, the Network will use the delegated entity's entire list of Providers to randomly select the files. Electronic files must be sent in a secure format, and no personal health information (PHI) should be exchanged in the credentialing file review process. Delegated Credentialing Entity is required to submit to the Network by email, mail or fax, quarterly reports of newly approved or terminated providers.

5. If GEHA delegates the credentialing function to Delegated Credentialing Entity and Delegated Credentialing Entity further delegates the credentialing function to a third party, such third party shall be considered a subdelegated credentialing entity under this Agreement. Such subdelegated credentialing entity shall be subject to all of the terms, conditions and limitations imposed by this Agreement for a delegated credentialing entity. Delegated Credentialing Entity hereby attests that it utilizes the services of such third party for purposes of credentialing all of its Participating Providers and will provide GEHA with a copy of such third party's credentialing policies to attach to this Agreement. If Delegated Credentialing Entity does not subdelegate its credentialing process to a third party, this Section 5 shall be deemed to be "not applicable."

6. If GEHA does not delegate the credentialing function to Delegated Credentialing Entity under this Agreement, Sections 1 through 5 above shall be deemed to be "not applicable" and GEHA will credential Participating Providers as required by GEHA's Credentialing and Recredentialing Policies and Procedures.

7. Delegated Credentialing Entity's delegated or subdelegated credentialing functions under this Agreement are considered to be approved by GEHA and/or any Participating Providers credentialed by GEHA under this Agreement shall considered to be recredentialed by GEHA unless Delegated Credentialing Entity is otherwise notified in writing by GEHA.

Delegated or subdelegated credentialing services performed by Delegated Credentialing Entity must be performed in accordance with GEHA's credentialing requirements and URAC standards.

Practitioners
1) Primary Source Verify license
2) Primary Source Verify highest level of education/training/or
3) Primary Source Verify board certification
4) Copy of DEA and sedation certificates, if applicable
5) State licensing board sanctions – NPDB
6) Medicare/Medicaid sanctions - OIG
7) Sanction history (5 Years)
8) Copy of Insurance face sheet
9) Five year work history

Timeframe for practitioners
1) Recredentialing cycle every three years
2) Application signed and dated not more than 180 days prior to credentialing committee review
3) Primary and secondary source verification is not collected more than 6 months prior to review
4) All documents must be current at the time that it goes to the Credentialing committee

Committee
1) Dates and documentation

Ongoing Monitoring
1) Reports of disciplinary actions published by state licensing boards and the US department of Health and Human Services, and review of the Office of Inspector General (OIG) Exclusion List, National Practitioner Data Bank (NPDB) Reports, the Office of Foreign Assets Control (OFAC) Specially Designated Nationals List and the General Service Administration Excluded Parties List System (EPLS).

Policy and Procedures
1) Review of policy and procedures

Application
1) Completed application
2) Signed and dated application with attestation that the information submitted is complete and accurate

Delegated Credentialing Entity shall submit a copy of its or its third party's credentialing policies and procedures to GEHA on an annual basis and upon request by GEHA. Delegated Credentialing Entity shall also submit copies of credentialing files or allow GEHA to perform an onsite review of credentialing files on an annual basis upon request by GEHA. If GEHA determines Delegated Credentialing Entity's or its third party's credentialing policies and procedures no longer meet GEHA's credentialing requirements and URAC standards, GEHA will notify Delegated Credentialing Entity and Delegated Credentialing Entity will have sixty (60) calendar days to make corrections or require its third party to make corrections to the identified problems or GEHA may withdraw its delegation or subdelegation to Delegated Credentialing Entity of the credentialing function.

If Delegated Credentialing Entity further delegates organizational functions pursuant to this Agreement, those functions shall be subject to the terms of this Agreement and in accordance with URAC standards.

Written Agreement Between
Connection Dental Network and Providers

The following items are hereby incorporated in the Provider Manual by reference and are available to all participating providers upon request.

1. Conditions for participation as a participating provider – All providers must meet GEHA's minimum professional requirements and credentialing criteria in order to become a participating provider in the network.

2. Obligations and responsibilities of the organization and the participating provider, including any obligations for the participating provider to participate in the organization's management, complaint, or other programs.

3. Events that may result in the reduction, suspension, or termination of network participation privileges.

4. The specific circumstances under which the network may require access to consumers' medical records as part of the organization's programs or health benefits.

5. Health care services to be provided and any related restrictions.

6. Requirements for claims submission and any restrictions on billing of consumers.

7. Mechanisms for dispute resolution by participating providers.

8. Term of the contract and procedures for terminating the contract.

9. Requirements with respect to preserving the confidentiality of patient health information.

10. Prohibitions regarding discrimination against consumers.

GEHA'S Minimum Professional Requirements For Connection Dental Network

1. All providers must either sign a written agreement to join the network or have a duly authorized signature party sign a written agreement on behalf of the provider to join the network.

2. All providers must have sufficient staffing and equipment and appropriate office hours necessary to provide dental services.

3. With the exception of providers in United States territories, all providers must carry professional liability insurance, which at a minimum must meet any requirements imposed by state law.

4. Providers must submit claims prior to each Plan's timely filing deadline in order for such claims to be considered for payment.

5. Providers must provide care and services which are of a quality consistent with generally accepted standards and practices in the dental community and comply with the Network's Quality Assurance Program, which is included in the GEHA/Connection Dental Network Credentialing, Recredentialing and Quality Assurance Program Policies and Procedures.

6. Providers must be credentialed by the network or credentialed by a contracting party, and must be eligible to participate in Medicare, Medicaid and other State and Federal programs in order to participate in the network. Providers credentialed by the network are recredentialed every three years. Providers must cooperate with the credentialing and recredentialing processes.

7. An application to the Network shall be considered complete when a completed and signed Participating Provider Agreement and a completed and signed application, along with the supporting documentation, have been received by the Network.

8. Providers shall use their best judgment with respect to patient care in the provision of Covered Services to a Covered Enrollee.

9. Providers shall notify the Network of changes of name, address, telephone number,tax identification number, office hours, panel closings, changes in practitioners at an office or reduction of services to Connection Dental Network by completing a "Contact Us" form at connectiondental.com or by sending the information in writing to the following address GEHA/Connection Dental Network, 310 NE Mulberry Street, Lee's Summit, MO 64086, phone number 800.505.8880; or by facsimile to 816.257.4439

10. Providers shall annually complete and comply with training requirements associated with GEHA Compliance, Code of Conduct, and Fraud Waste and Abuse Training, as assigned or noted in newsletter.

Initial Credentialing Criteria

1. **Provider Application –** A completed, signed, and dated Connection Dental Network or state-required Credentialing Application, along with all supporting documentation, must be submitted. The Application cannot be signed and dated more than 180 days prior to the Peer Review Committee review.
   - If the provider submits a standardized application form, it must contain all information according to the credentialing criteria.

2. **Verification –** All documentation must be provided with the Application, which includes primary or secondary source verification as follows:

   a. **State License –** The applicant must have a current, active, and valid state dental license. All current license(s) shall be primary source verified by a state licensing board. Current license verification must include the expiration date of the license and the date it was verified. The current state license must be in effect at the time of the credentialing decision. This is subject to individual state requirements. For providers in North Carolina, state licensure information will also be gathered for expired licenses which will be primary or secondary source verified. **EXCEPTION**: An MD with an Oral & Maxillofacial Specialty may not be required to possess a dental license in addition to a medical license.
      - If a state licensing investigation or action has been taken against the applicant in any state within the last 5 years, this ***dictates review by the Peer Review Committee.***
      - If a state license is currently revoked, suspended or expired, ***the application does not meet the credentialing criteria.***
      - If a state licensing investigation is dismissed without action ***Peer Review is not required.***
      - If provider practices on a Federal Enclave such as Native American Reservation, provider may be licensed by any state in the United States.

   a. **Board Certification, if applicable or highest level of education –** Certification is verified by accessing primary source verification from the appropriate American Board of Dental Specialties On-line Verification Program via the internet, by contacting the applicable Board, or confirmation is verified directly from the Board. The certification must be in effect at the time of the credentialing decision.

   b. **Education/Training –** Primary source verification of applicant's most recently completed, highest level of education, if not Board Certified.
      - Incomplete verification ***dictates Peer Review***.

   c. **DEA Certificate, if applicable.**
      - Primary source verify the DEA by the National Technical Information Services (NTIS) or secondary source verify by a current copy that is valid at the time of the credentialing decision.
      - If a DEA licensing investigation or action has been taken against the applicant within the last 5 years, this ***dictates further review by the Peer Review Committee.***

   d. **Sedation/Anesthesia, if applicable.**
      - Primary source verify the Sedation/Anesthesia through the issuing entity and secondary source, where primary source is not available, with a current copy or waiver that is valid at the time of the credentialing decision.

e. **Malpractice Insurance -** Current and valid copy that is valid at the time of the initial credentialing decision.
   - If insurance cover sheet is submitted, then the cover sheet must include the name of the practitioner, the expiration date and the liability covered. If the cover sheet does not include the name of the practitioner, then a photocopy of those covered under the plan must be submitted on a sheet that includes the insurer's letterhead. **EXCEPTION:** Self-insured, Federal Tort (FTCA) and State Tort Insurance policies are acceptable and may not include provider's name.
   - If the provider does not carry professional liability insurance ***the application does not meet the credentialing criteria***.
   - If professional liability insurance has been denied, canceled, or not renewed for unprofessional conduct within the last 5 years, this ***dictates review by the Peer Review Committee***.
   - United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands) may be exempt from professional liability insurance requirements. If a provider resides in a United States territory and does not maintain professional liability insurance this ***dictates review by the Peer Review Committee.***

NOTE: Primary source verification may include State Licensing Board, school/residency/ training program, Board Certification via the ADA master file, Dental Board, the American Board of Dental Specialties, the Education Commission for Foreign Graduates, or Special Board of Registry.

3. **Admitting Privileges --** Provider may or may not have admitting privileges; however, if hospital privileges were surrendered during investigation, suspended or limited within the last 5 years, this ***dictates review by the Peer Review Committee***.

4. **Work History** -- Documentation of the immediately preceding 5-year work history of the provider must be provided. If a provider has fewer than 5 years of work history, the time frame starts at the initial licensure date. If a provider has had continuous employment for 5 years or more with no gap, the Provider may provide the year work started without the month. If there is a gap of six months or more, explanation from the provider is required either verbally or in writing. If the gap in employment exceeds one year, the Provider must clarify the gap in writing.

5. **Date of Birth** – Provider is required to include his or her date of birth on the Application.

6. **All malpractice issues** during the prior 5 years must be taken into account in the evaluation of the provider for entry into the network. Verified by National Practitioner Data Bank (NPDB).
   - **Malpractice cases** that occur during an applicant's internship or residency will be the only exception when the applicant was under a licensed physician's supervision during that time period.
   - **Peer Review Committee review will be required** on all providers with malpractice issues involving: Two or more cases closed with payment and/or any one case with a settlement of $30,000 or more.

7. **Any finding of guilt or entering a plea of guilty or nolo contendere (or settlement during criminal prosecution) for any felony or any offense reasonably related to the qualifications, functions or duties of the medical or dental profession, or for any offense an essential element of which is fraud, dishonesty, an act of violence or an act involving moral turpitude, with the exception of North Carolina where only convictions of a felony or misdemeanor under state or federal law will be considered.** If discovered, this ***dictates review by the Peer Review Committee.***

8. **Provider is debarred or suspended** from participation in government programs (e.g., Medicare or Medicaid). Verified by reviewing disciplinary actions published by the Office of Inspector General (OIG) Exclusion List, determining whether the provider is included on the Office of Foreign Assets Control's (OFAC's) Specially Designated Nationals List or determining whether the provider is included in the General Service Administration's Excluded Parties List System (EPLS). If this is noted, ***the application does not meet the credentialing criteria.***

9. **Provider has had chronic illness, physical defects or substance abuse** that would impair his or her ability to practice within the last 5 years. If this is discovered, this ***dictates review by the Peer Review Committee***

10. **Provider documents destroyed due to a disaster**. If this is discovered, this ***dictates review by the Peer Review Committee.***

11. **Provider fails/refuses to submit all required credentialing information** or provider fails/refuses to submit additional information or clarification(s) requested by the Peer Review Committee within the 180-day credentialing process deadline. This will result in the credentialing file being closed and the provider will need to reapply to the network.

12. **Quality Assurance Program issues -** Quality Assurance Program issues that occurred during the previous 5 years are considered in the credentialing process.

13. The **Network credentialing staff may *dictate a File review by the Peer Review Committee Chairman*** at their discretion.

All documentation supporting the Application that is subject to expiration dates must be current and valid at the time of the Peer Review decision, and any credentialing verifications must be performed within the 180 day timeframe prior to the Peer Review Committee decision.

All criteria listed above are subject to revisions and/or additions due to changes in federal and state laws, ADA guidelines and the Credentialing policies of GEHA.

Recredentialing Criteria

1. **Supporting Documentation –** All documentation must be provided with the signed and dated Recredentialing Application/Attestation. The Recredentialing Application/Attestation cannot be signed and dated more than 180 days prior to the Peer Review Committee review.

   a. **State Dental License.** The applicant must have a current, active, and valid state dental license. All current license(s) shall be primary source verified by the applicable licensing entity. The license must be in effect at the time of the credentialing decision. This is subject to individual state requirements.
   EXCEPTION: An MD with an Oral & Maxillofacial Specialty may not be required to possess a dental license in addition to a medical license.
   - If a state licensing investigation or action has been taken against the physician within the last 3 years, this ***dictates review by the Peer Review Committee.***
   - If a state license is currently revoked, suspended or expired, ***the application does not meet the credentialing criteria.***
   - If a state licensing investigation is dismissed without action **Peer Review is not required.**
   - If a state license is in a grace period for renewal but not considered to be inactive or restricted, the network will consider the state license to be current through the last day of the grace period. Once any grace period for renewal expires, the license shall no longer be considered current or valid.

   b. **Board Certification, if applicable**. Primary source verify Board Certification by accessing the American Board of Dental Specialties via the internet or by contacting the applicable Board for confirmation.

   c. **Education/Training –** Primary source verification of applicant's highest level of education obtained since previous credentialing occurrence, if not Board Certified.
   - Incomplete verification ***dictates Peer Review***.

   d. **DEA Certificate, if applicable. -** Primary source verify the DEA by the National Technical Information Services (NTIS) or secondary source verify by a current copy that is valid at the time of the recredentialing decision.
   - If a DEA licensing investigation or action has been taken against the provider within the last 3 years, this ***dictates further review by the Peer Review Committee.***

   e. **Sedation/Anesthesia, if applicable.**
   - Primary source verify the Sedation/Anesthesia through the issuing entity and secondary source, where primary source is not available, with a current copy or waiver that is valid at the time of the credentialing decision.

   f. **Malpractice Insurance – Current and valid copy that is valid at the time of the recredentialing decision.**
   - If the individual provider's name is not listed on the face sheet (such as an employee of an institution) a letter must accompany the application documenting employment status with group insurance coverage.
   EXCEPTION: Self-insured, Federal Tort (FTCA) and State Tort Insurance policies are acceptable and may not include provider's name.

- If it is noted that the provider does not currently carry professional liability insurance, ***the application does not meet the credentialing criteria.***
- If professional liability insurance has been denied, canceled, or not renewed for unprofessional conduct within the last 3 years, this ***dictates review by the Peer Review Committee***.
- United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands) may be exempt from professional liability insurance requirements. If a provider resides in a United States territory and does not maintain professional liability insurance this ***dictates review by the Peer Review Committee.***

2. **Provider may or may not have admitting privileges;** however if hospital privileges were surrendered during investigation, suspended or limited within the last 3 years, this ***dictates review by the Peer Review Committee.***

3. **All malpractice issues** during the prior 3 years must be taken into account in the evaluation of the provider for continued participation in the network.
   - **Peer Review Committee will be required** on all providers with malpractice issues not previously reviewed involving: Two or more cases and/or any one case with a settlement of $30,000 or more.

4. **Any finding of guilt or entering a plea of guilty or nolo contendere (or settlement during criminal prosecution) within the last 3 years for any felony or any offense reasonably related to the qualifications, functions or duties of the medical or dental profession, or for any offense an essential element of which is fraud, dishonesty or an act of violence or an act involving moral turpitude, with the exception of North Carolina where only convictions of a felony or misdemeanor under state or federal law will be considered.** If discovered, this ***dictates review by the Peer Review Committee.***

5. **Provider is debarred or suspended** from participation in a government program (e.g., Medicare or Medicaid) during the last 3 years. If this is noted, ***the application does not meet the credentialing criteria.***
   - Routine monitoring by reviewing disciplinary reports published by the Office of Inspector General, the Office of Foreign Assets Control, and the General Service Administration on an ongoing basis. If it is noted that a provider is debarred or suspended from participating in government programs, ***the application does not meet the credentialing criteria.***

6. **Provider has developed chronic illness, physical defects or substance abuse** that would impair his or her ability to practice during the last 3 years. If this is discovered, this ***dictates review by the Peer Review Committee.***

7. **Provider documents destroyed due to a disaster.** If this is discovered, this ***dictates review by the Peer Review Committee.***

8. **Provider fails/refuses to submit all required recredentialing information** or provider fails/refuses to submit additional information within the 180-day recredentialing process deadline or a provider fails/refuses to submit additional information or clarification(s)

requested by the Peer Review Committee. This will result in a voluntary termination by the provider.

9. **Quality Assurance Program issues –** All Quality Assurance issues that occurred during the previous 3 years are considered in the recredentialing process.

10. **The Network credentialing staff may *dictate a File review by the Peer Review Committee*** at their discretion.

All documentation supporting the Application that is subject to expiration dates must be current and valid at the time of the Peer Review Committee's decision, and any credentialing verifications must be performed within the 180-day timeframe prior to the Peer Review Committee decision.

All criteria listed above are subject to revisions and/or additions due to changes in federal and state laws, ADA guidelines and the Credentialing policies of GEHA.

Obligations and Responsibilities of the Connection Dental Network Participating Provider

GEHA agrees to (a) market its Connection Dental Network to other entities; (b) maintain an administrative staff to assist the Participating Provider and his/her staff members; (c) provide administrative reference materials regarding participation to the Participating Provider; (d) maintain a toll-free telephone number for the use of the Participating Provider and his/her staff members; (e) make available to Covered Enrollees, other entities, and Participating Providers a directory of Participating Providers who participate in the Connection Dental Network. Directory information may be made available via paper or electronic mediums and/or toll-free telephone service. GEHA shall use its best efforts to provide current, accurate directory information; (f) use its best efforts to arrange for the distribution of identification cards that will include the Connection Dental Network logo, claim filing procedures as needed and eligibility inquiry information; (g) submit and use its best efforts to require other Payors to submit an explanation of benefits or remittance advice that identifies the contractual source of any discount to the Participating Provider; and (h) not interfere or intervene and use best efforts to require that other Payors not interfere or intervene in any manner in the diagnosis or treatment rendered by a Participating Provider to a Covered Enrollee or with any communication between a Participating Provider and a Covered Enrollee. Benefit determinations made by a Payor shall not constitute interference.

GEHA and Payors shall use best efforts to make all payments due to the Participating Provider within thirty (30) days of receipt of a clean claim. GEHA shall not be an insurer, guarantor, or underwriter of the responsibility or liability of any other Payor to provide payments pursuant to any other Payor's plan.

The Participating Provider agrees that he/she will: (a) meet GEHA's minimum professional requirements and credentialing criteria and provide dental services that are consistent with standards of good dental practice in the United States and promptly notify GEHA of any guilty plea or conviction of a felony; chronic illness, physical defect, or use of any illegal drugs or substance abuse that would impair the ability to practice; (b) maintain an unrestricted license(s) to practice dentistry in the state where such services are to be provided; perform only those services that are within the lawful scope of any such license(s); and notify GEHA within five (5) business days in the event of the initiation of any disciplinary action of any kind taken against Participating Provider and of the ultimate disposition of such action; (c) maintain sufficient staffing and equipment and appropriate office hours to provide Covered Services; (d) accept the lesser of the Fee Schedule amounts for the procedures listed, which is attached hereto, or the Participating Provider's usual billed charges as payment in full and not balance bill Covered Enrollees for any amount in excess of the lesser of the Fee Schedule amounts for the procedures listed or the Participating Provider's usual billed charges. The Participating Provider shall be required to accept the Fee Schedule amount for all services listed on the Fee Schedule unless prohibited by law. Participating Provider shall also be required to bill Covered Enrollees for any coinsurance, copayment or deductible as permitted by a particular plan covered by the Agreement; (e) agree that if a service is not listed on the Fee Schedule, no discount shall be taken, and the Participating Provider will be reimbursed based on the plan and the total billed charges. Nothing shall prohibit Participating Provider from pursuing any recourse against the insuring corporation, Payor or their successors; (f) agree to cooperate with GEHA and Payors in the claims filing and coordination of benefits as determined by the benefit plans and applicable law; (g) maintain such dental records as required by state law and provide, upon request from GEHA or other Payor and with appropriate patient authorization, copies of dental records,

charging and treatment information, including x-rays and diagnostic records; (h) be responsible for the dental care and provider-patient relationship for his/her patients. The final decision to provide or receive dental care is made between the Participating Provider and Covered Enrollee; (i) provide dental care services and supplies to Covered Enrollees with the same quality and availability of services provided to all patients treated by the Participating Provider, and not discriminate on the basis of race, color, creed, ancestry, national origin, age, physical, mental or sensory disability, health status, religion, sex, sexual orientation, marital status, type of dental benefit plan or source of payment; (j) furnish covered services to Covered Enrollees without regard to the Covered Enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services; however, this requirement does not apply to circumstances when the Participating Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions; (k) maintain comprehensive general liability and malpractice insurance in amounts determined by GEHA. Such amounts shall at least meet any minimum amounts required by state law(s). The Participating Provider agrees to notify GEHA within five (5) business days of his/her receipt of notice of any change in such coverage; (l) cooperate with and follow credentialing, recredentialing and appeal procedures established by GEHA and Payors; (m) allow GEHA, its subsidiaries, and other entities to use the Participating Provider's name, office address(es) and telephone number(s), practice information and other pertinent information in its marketing, directory information and other materials, and for regulatory purposes. Participating Provider will provide notice to GEHA within ten (10) business days of changes to his or her name, address, Tax Identification Number or practice information. All changes in Tax Identification Numbers for Participating Provider will be applied to his or her network status unless otherwise notified by Participating Provider. If Participating Provider moves to another state or zip code after initial contracting, the Fee Schedule will change to that applicable to the new state or zip code in which Participating Provider will be practicing. If Participating Provider moves or closes his or her office after initial contracting and does not notify GEHA in writing, GEHA will make a good faith attempt to locate Participating Provider; however, if GEHA is unable to locate the Participating Provider, he or she may be terminated by GEHA without written notice or cause unless prohibited by law; (n) accept the Connection Dental logo on any identification card provided to Covered Enrollees and extend the Connection Dental Fee Schedule to such Covered Enrollees with the understanding that eligibility verification procedures must be followed; (o) request, accept and maintain written assignment of benefits; (p) maintain all dental records for a period of time as required by state or federal law but in no event less than two (2) years, and make all such records available to the administrator of the state for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to administrator beneficiaries, and to make such records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Enrollees subject to applicable state and federal laws related to the confidentiality of medical or health records; (q) continue to fulfill all obligations with respect to Covered Enrollees under his or her care as of the date of termination until the current course of treatment is complete, care of the Covered Enrollee is transferred to another Participating Provider, or as otherwise required by state or federal law; (r) cooperate, participate in and comply with all policies and procedures of GEHA or any Payor which may be in effect from time to time, none of which shall override the professional or ethical responsibility of the Participating Provider or interfere with the Participating Provider's ability to provide information or assistance to their patients, and that are provided on GEHA's website at connectiondental.com or provided to Participating Provider by GEHA or Payors in accordance with applicable law; (s) arrange for call coverage or other back-up to provide service in accordance with Payors' policies and procedures for provider accessibility as provided on GEHA's website at connectiondental.com or as provided to Participating Provider by GEHA or

Payors in accordance with applicable law; (t) comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time; and (u) authorize GEHA to contract with Payors, or with entities on behalf of Payors, to make Participating Provider's services available to Payors upon the same terms and conditions that such services are made available to GEHA pursuant to this Agreement.

The Effective Date of the Agreement shall be the date provided to Participating Provider in the welcome letter.

The initial term of the Agreement shall commence on the Effective Date and terminate on the Anniversary Date as defined in the Agreement. The Agreement shall automatically renew on its Anniversary Date for additional one-year terms ending on each subsequent Anniversary Date unless terminated by GEHA or Participating Provider in accordance with Paragraphs governing automatic termination, termination without cause or for default, or immediate termination, or unless either party gives notice of its intent to terminate at the end of the then current term by providing ninety (90) days advance written notice. If the Agreement is terminated at the end of the then current term or if a Participating Provider voluntarily terminates from the Connection Dental Network, the Participating Provider shall not be entitled to the procedural rights set forth in the Network Appeals/Grievances policy.

A Participating Provider's participation in the Connection Dental Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No provider shall be entitled to the procedural rights set forth in the Network Appeals/Grievances policy as the result of an automatic termination imposed pursuant to this section. (a) The Participating Provider's license/authorization to practice or to prescribe controlled substances is currently revoked in any state in which the Participating Provider is or will be providing services pursuant to this Participating Provider Agreement. (b) The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical profession, for any offense an essential element of which is fraud, dishonesty or an act of violence. (c) The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TriCare or the Federal Employees Health Benefit Program (FEHBP). (d) The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

Either GEHA or the Participating Provider may terminate the Agreement, with or without cause, upon ninety (90) days' prior written notice to the other party, unless prohibited by applicable law. Termination shall be effective on the last day of the month in which the ninety (90) days' notice requirement is met. Further, the Agreement may be terminated if there is a default in the performance of the terms and conditions of the Agreement which default has not been cured within ninety (90) days following the effective date of written notice of default.

Notwithstanding the paragraph governing termination without cause or termination for default, GEHA may terminate the Agreement immediately for any of the following reasons: (a) Any falsification of any information on the Participating Provider's application submitted to GEHA or fraud committed on any documentation; or (b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or (c) Institution of bankruptcy, receivership, insolvency,

liquidation or other similar proceedings by or against the Participating Provider; or (d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or (e) Membership in the GEHA Connection Dental Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or (f) Noncompliance with HIPAA.

GEHA shall notify Participating Provider in writing of the reason for Participating Provider's involuntary termination, if applicable. Upon termination, the Participating Provider shall be entitled to those rights of appeal or grievance as set forth in the policies and procedures of GEHA if Participating Provider is entitled to such appeal or grievance pursuant to said policies and procedures. Further, Participating Provider shall not be entitled to such appeal and grievance policies and procedures if such policies and procedures have previously been implemented with respect to Participating Provider. If applicable, GEHA and Participating Provider agree to follow such policies and procedures. Notwithstanding other provisions in Article III of the Agreement, GEHA and Participating Provider agree to abide by the laws of any applicable state which may apply to terminations. Participating Provider shall be obligated to complete a course of treatment begun prior to the effective date of termination.

In the event of insolvency of GEHA or Payor or other cessation of operations, benefits to Covered Enrollees will continue through the period for which the premium has been paid, if applicable, and Participating Provider will cooperate in the transition of administrative duties and records to the succeeding company or provider, as the case may be. The liability of a party to the Agreement may not be transferred to another party or to Covered Enrollees. Participating Provides are not required to indemnify Payors for any expenses or liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against the Payor based on the Payor's management decisions, utilization review provisions or other policies, guidelines or actions. Nothing in this section, however, shall in any way affect or limit Participating Provider's right or obligation to collect deductibles, coinsurance, or copayments, as specifically provided in the plan, or fees for non-covered services delivered to Covered Enrollees. This provision shall survive termination of this Agreement for services rendered prior to the termination of this Agreement, regardless of the cause of the termination.

GEHA may increase all or part of the Fee Schedule at any time without notice to the Participating Provider. GEHA may not decrease the Fee Schedule unless the Participating Provider is notified in writing sixty (60) days prior to the effective date of the decrease or as otherwise required by law or as otherwise required by law.

PPE is a requirement of the safe provision of dental care and is considered inclusive under all billable procedures. Unless otherwise allowed by law, a member may not be charged separately for PPE charges as this is considered unbundling and an unacceptable billing practice. Please contact the Plan directly for information regarding coverage for PPE.

GEHA and Participating Provider agree that both parties shall at all times be acting and performing as independent contractors. The Agreement shall not be construed to create any relationship of employer and employee, partners, joint venturer or principal and agent.

GEHA and other Payors shall comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and

Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time. With regard to the operation of the GEHA dental plans, state law is specifically preempted and all matters relating to benefits or the payment of benefits by GEHA shall be resolved by the United States Office of Personnel Management ("OPM") with respect to the Federal Employee Dental and Vision Benefits Program dental plan and in accordance with the disputed claims procedures and the regulations of the OPM or in accordance with the GEHA benefit plan dispute resolution procedures with respect to the Connection Dental *Plus* dental plan. Any applicable federal and state laws, rules and regulations not specifically mentioned in the Agreement are contained in Connection Dental Network's State Specific Policies & Procedures in its Provider Manual as may be amended from time to time, are hereby incorporated by reference into the Agreement, and are available at connectiondental.com or upon request. If the terms of the Agreement conflict with the State Specific Policies & Procedures established by GEHA with regard to applicable federal and state laws, rules and regulations, the State Specific Policies & Procedures shall prevail.

GEHA, Participating Provider, any other Payor or entity, or any of their respective employees or agents shall not be held liable for any negligence or intentional wrongdoing on the part of another or any costs, expenses or attorneys' fees associated therewith.

GEHA is not liable for any claims for services provided by a Participating Provider to a Covered Enrollee who is entitled to benefits payable under any other plan other than covered services under the GEHA Plan, which operates pursuant to the FEHBP, or Connection Dental Plus.

GEHA and Participating Provider agree that both parties shall maintain patient record confidentiality and not disclose any such patient information without the patient's written consent or as otherwise permitted by law.

In the event that any dispute arises with regard to the performance or interpretation of any of the provisions of this Agreement, GEHA and Participating Provider shall use best efforts to resolve such disputes. In the event such disputes cannot be resolved between GEHA and Participating Provider, such disputes shall be submitted to an arbitrator selected by the American Arbitration Association unless prohibited by applicable law, in which case applicable law shall govern this section. GEHA and Participating Provider agree to be bound by the decision of the arbitrator and accept the decision as the final determination. Judgment upon decision of the arbitrator may be entered in any court of competent jurisdiction. GEHA and Participating Provider shall each bear its own cost plus one-half (1/2) the cost of arbitration. Disputes regarding benefits or the payment of benefits for services provided to Covered Enrollees are excluded from coverage under this provision and shall be resolved in accordance with the Payors' appeals processes. Also, issues involving the termination of Participating Provider and any appeals or grievances related thereto are covered by policies and procedures of GEHA and are not covered by this arbitration provision.

The Agreement shall be governed by and construed in accordance with the laws of the State of Missouri and any applicable federal law(s). The substantive law of Missouri shall solely govern the Agreement and no cause of action not specifically recognized in the State of Missouri shall be implied or construed to exist.

For purposes of the Agreement, a Covered Enrollee means any person who is eligible to receive dental benefits offered by GEHA or an entity who has an agreement with GEHA.

For purposes of the Agreement, Payor means the party responsible for providing reimbursement for dental care services.

To the extent that the Agreement allows for sub-contracting with providers and facilities, all sub-contracts will be subject to the terms of the Agreement and all applicable federal and state laws, rules and regulations.

If required by applicable law, Payors shall notify Participating Providers of their responsibilities with respect to such Payor's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, and confidentiality requirements by making such policies and programs available to Participating Providers on Connection Dental Network's website at connectiondental.com under the "Resources/Payor Documents" tab or available from the Payor upon request by the Participating Provider. Any notifications required by applicable law to be provided to Participating Providers by Payors shall also be posted on the Connection Dental Network website under the "Resources/Payor Documents" tab and if required, shall be submitted to Participating Providers in writing, except that required Fee Schedule notifications shall be sent by GEHA to Participating Providers. Connection Dental Network's documents, procedures, and other administrative policies and programs referenced in this Agreement are available for review by providers at connectiondental.com or available upon request. All information made available to a Participating Provider in accordance with the requirements of applicable state or federal law shall be confidential and shall not be disclosed to any individual or entity not involved in the provider's practice or the administration of such practice without the prior written consent of GEHA.

Events that may result in the reduction, suspension, or termination of Connection Dental Network Participation Privileges

The Agreement shall automatically renew on its Anniversary Date for additional one-year terms ending on each subsequent Anniversary Date unless terminated by GEHA or Participating Provider in accordance with paragraphs governing automatic termination, termination without cause or for default, or immediate termination, or unless either party gives notice of its intent to terminate at the end of the then current term by providing ninety (90) days advance written notice. If this Agreement is terminated at the end of the then current term or if a Participating Provider voluntarily terminates from the Connection Dental Network, the Participating Provider shall not be entitled to the procedural rights set forth in the Network Appeals/Grievances policy.

A Participating Provider's participation in the Connection Dental Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No provider shall be entitled to the procedural rights set forth in the Network Appeals/Grievances policy as the result of an automatic termination imposed pursuant to this section. (a) The Participating Provider's license/authorization to practice or to prescribe controlled substances is currently revoked in any state in which the Participating Provider is or will be providing services pursuant to this Participating Provider Agreement. (b) The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical profession, for any offense an essential element of which is fraud, dishonesty or an act of violence. (c) The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TriCare or FEHBP. (d) The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

Either GEHA or the Participating Provider may terminate the Agreement, with or without cause, upon ninety (90) days' prior written notice to the other party, unless prohibited by applicable law. Termination shall be effective on the last day of the month in which the ninety (90) days' notice requirement is met. Further, the Agreement may be terminated if there is a default in the performance of the terms and conditions of the Agreement which default has not been cured within ninety (90) days following the effective date of written notice of default.

Notwithstanding the paragraph governing termination without cause or termination for default, GEHA may terminate the Agreement immediately for any of the following reasons: (a) Any falsification of any information on the Participating Provider's application submitted to GEHA or fraud committed on any documentation; or (b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or (c) Institution of bankruptcy, receivership, insolvency, liquidation or other similar proceedings by or against the Participating Provider; or (d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or (e) Membership in the GEHA Connection Dental Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or (f) Noncompliance with HIPAA.

If a Participating Provider moves or closes his or her office after initial contracting and the Participating Provider does not notify GEHA in writing, GEHA will make a good faith attempt to

locate the Participating Provider; however, if GEHA is unable to locate the Participating Provider, this Agreement may be terminated by GEHA without written notice or cause unless prohibited by law.

Specific Circumstances under which the Connection Dental Network may require access to consumers' medical records as part of the network's programs or health benefits

The Participating Provider agrees that he/she will maintain such dental records as required by state law and provide, upon request from GEHA or other Payor and with appropriate patient authorization, copies of dental records, charging and treatment information, including x-rays and diagnostic records.

Health Care Services to be provided and any relation restrictions for Connection Dental Network

The Participating Provider agrees that he/she will provide dental care services and supplies to Covered Enrollees with the same quality and availability of services provided to all patients treated by the Participating Provider, and not discriminate on the basis of race, color, creed, ancestry, national origin, age, physical, mental or sensory disability, health status, religion, sex, sexual orientation, marital status, type of dental benefit plan or source of payment;

The Participating Provider agrees that he/she will be responsible for the dental care and provider-patient relationship for his/her patients. The final decision to provide or receive dental care is made between the Participating Provider and Covered Enrollee.

Requirements for claims submission and any restrictions on billing of consumers for Connection Dental Network

The Participating Provider agrees that he/she will accept the lesser of the Fee Schedule amounts for the procedures listed, which is attached hereto, or the Participating Provider's usual billed charges as payment in full and not balance bill Covered Enrollees for any amount in excess of the lesser of the Fee Schedule amounts for the procedures listed or the Participating Provider's usual billed charges. The Participating Provider shall be required to accept the Fee Schedule amount for all services listed on the Fee Schedule unless prohibited by law. Participating Provider shall also be required to bill Covered Enrollees for any coinsurance, copayment or deductible as permitted by a particular plan covered by the Agreement.

PPE is a requirement of the safe provision of dental care and is considered inclusive under all billable procedures. Unless otherwise allowed by law, a member may not be charged separately for PPE charges as this is considered unbundling and an unacceptable billing practice. Please contact the Plan directly for information regarding coverage for PPE

If a Participating Provider moves to another state or zip code after initial contracting, the Fee Schedule will change to that applicable to the new state or zip code in which Participating Provider will be practicing.

GEHA and Payors shall not refuse to contract with or compensate for covered services an otherwise eligible Participating Provider solely because such Participating Provider has in good faith: (a) communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of GEHA's or Payors' health benefit plans as they relate to the needs of such Participating Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by GEHA or a Payor for services provided to the Covered Enrollee.

The Participating Provider agrees that he/she will cooperate, participate in and comply with all policies and procedures and programs of GEHA or any Payor, none of which shall override the professional or ethical responsibility of the Participating Provider or interfere with the Participating Provider's ability to provide information or assistance to their patients, and that are provided on GEHA's website at connectiondental.com or provided to Participating Provider by GEHA or Payors in accordance with applicable law.

Mechanisms for dispute resolution by participating Providers in Connection Dental Network

1. Administrative Appeals/Disputes Initiated by Participating Providers. Please see the GEHA/ Connection Dental Network General Policies & Procedures for Network Appeals/Disputes included within this Provider Manual for administrative disputes/appeals related to the performance or interpretation of the Participating Provider Agreement.

2. GEHA/Connection Dental Network Participation Appeals/Disputes. Please see the GEHA/Connection Dental Network General Policies & Procedures for Network Appeals/Disputes included within this Provider Manual for participation disputes/appeals that are available to Participating Providers. Please also see the GEHA/Connection Dental Network Credentialing, Recredentialing and Quality Assurance Program Policies and Procedures available at connectiondental.com under the Credentialing Info tab.

3. Claims Appeals/Disputes. Disputes regarding benefits or the payment of benefits for services provided to Covered Enrollees are excluded from coverage under the Arbitration provision of the Participating Provider Agreement and shall be resolved in accordance with the Payors' appeals processes. With regard to the operation of the GEHA dental plans, including the Federal Employee Dental and Vision Benefits Program and Connection Dental Plus, state law is specifically preempted and all matters relating to benefits, billing or the payment of benefits by GEHA shall be resolved in accordance with the procedures outlined in the applicable benefit brochure

Term of the contract and procedures for terminating the contract for Connection Dental Network

The initial term of the Agreement shall commence on the Effective Date and terminate on the Anniversary Date as defined in the Agreement. The Agreement shall automatically renew on its Anniversary Date for additional one-year terms ending on each subsequent Anniversary Date unless terminated by GEHA or Participating Provider in accordance with Paragraphs governing automatic termination, termination without cause or for default, or immediate termination, or unless either party gives notice of its intent to terminate at the end of the then current term by providing ninety (90) days advance written notice. If the Agreement is terminated at the end of the then current term or if a Participating Provider voluntarily terminates from the Connection Dental Network, the Participating Provider shall not be entitled to the procedural rights set forth in the Network Appeals/Grievances policy.

A Participating Provider's participation in the Connection Dental Network shall be automatically terminated as described herein as of the date of the occurrence of the event described herein. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred. No provider shall be entitled to the procedural rights set forth in the Network Appeals/Grievances policy as the result of an automatic termination imposed pursuant to this section. (a) The Participating Provider's license/authorization to practice or to prescribe controlled substances is currently revoked in any state in which the Participating Provider is or will be providing services pursuant to this Participating Provider Agreement. (b) The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical profession, for any offense an essential element of which is fraud, dishonesty or an act of violence. (c) The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TriCare or FEHBP. (d) The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

Either GEHA or the Participating Provider may terminate the Agreement, with or without cause, upon ninety (90) days' prior written notice to the other party, unless prohibited by applicable law. Termination shall be effective on the last day of the month in which the ninety (90) days' notice requirement is met. Further, the Agreement may be terminated if there is a default in the performance of the terms and conditions of the Agreement which default has not been cured within ninety (90) days following the effective date of written notice of default.

Notwithstanding the paragraph governing termination without cause or termination for default, GEHA may terminate the Agreement immediately for any of the following reasons: (a) Any falsification of any information on the Participating Provider's application submitted to GEHA or fraud committed on any documentation; or (b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or (c) Institution of bankruptcy, receivership, insolvency, liquidation or other similar proceedings by or against the Participating Provider; or (d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or (e) Membership in the GEHA Connection Dental Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or (f) Noncompliance with HIPAA.

GEHA shall notify Participating Provider in writing of the reason for Participating Provider's involuntary termination, if applicable. Upon termination, the Participating Provider shall be entitled to those rights of appeal or grievance as set forth in the policies and procedures of GEHA if Participating Provider is entitled to such appeal or grievance pursuant to said policies and procedures. Further, Participating Provider shall not be entitled to such appeal and grievance policies and procedures if such policies and procedures have previously been implemented with respect to Participating Provider. If applicable, GEHA and Participating Provider agree to follow such policies and procedures. Notwithstanding other provisions in Article III of the Agreement, GEHA and Participating Provider agree to abide by the laws of any applicable state which may apply to terminations. Participating Provider shall be obligated to complete a course of treatment begun prior to the effective date of termination.

The Participating Provider agrees that he/she will continue to fulfill all obligations with respect to Covered Enrollees under his or her care as of the date of termination until the current course of treatment is complete, care of the Covered Enrollee is transferred to another Participating Provider, or as otherwise required by state or federal law.

If a Participating Provider moves or closes his or her office after initial contracting and the Participating Provider does not notify GEHA in writing, GEHA will make a good faith attempt to locate the Participating Provider; however, if GEHA is unable to locate the Participating Provider, this Agreement may be terminated by GEHA without written notice or cause unless prohibited by law.

In the event of insolvency of GEHA or Payor or other cessation of operations, benefits to Covered Enrollees will continue through the period for which the premium has been paid, if applicable, and Participating Provider will cooperate in the transition of administrative duties and records to the succeeding company or provider, as the case may be.

Requirements with respect to preserving the confidentiality of patient health information for Connection Dental Network

The Participating Provider agrees that he/she will maintain all dental records for a period of time as required by state or federal law but in no event less than two (2) years, and make all such records available to the administrator of the state for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to administrator beneficiaries, and to make such records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Enrollees subject to applicable state and federal laws related to the confidentiality of medical or health records.

The Participating Provider agrees that he/she will comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time.

GEHA and other Payors shall comply with all applicable federal and state laws, rules and regulations, including applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), and regulations promulgated thereunder, as they may be amended from time to time. With regard to the operation of the GEHA dental plans, state law is specifically preempted and all matters relating to benefits or the payment of benefits by GEHA shall be resolved by the United States Office of Personnel Management ("OPM") with respect to the Federal Employee Dental and Vision Benefits Program dental plan and in accordance with the disputed claims procedures and the regulations of the OPM or in accordance with the GEHA benefit plan dispute resolution procedures with respect to the Connection Dental *Plus* dental plan. Any applicable federal and state laws, rules and regulations not specifically mentioned in the Agreement are contained in Connection Dental Network's State Specific Policies & Procedures in its Provider Manual as may be amended from time to time, are hereby incorporated by reference into the Agreement, and are available at connectiondental.com or upon request. If the terms of the Agreement conflict with the State Specific Policies & Procedures established by GEHA with regard to applicable federal and state laws, rules and regulations, the State Specific Policies & Procedures shall prevail.

GEHA and Participating Provider agree that both parties shall maintain patient record confidentiality and not disclose any such patient information without the patient's written consent or as otherwise permitted by law.

Prohibitions regarding discrimination against consumers for Connection Dental Network

The Participating Provider agrees that he/she will provide dental care services and supplies to Covered Enrollees with the same quality and availability of services provided to all patients treated by the Participating Provider, and not discriminate on the basis of race, color, creed, ancestry, national origin, age, physical, mental or sensory disability, health status, religion, sex, sexual orientation, marital status, type of dental benefit plan or source of payment.

The Participating Provider agrees that he/she will furnish covered services to Covered Enrollees without regard to the Covered Enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services; however, this requirement does not apply to circumstances when the Participating Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

The Network's Credentialing Program decisions are made in a non-discriminatory manner. Credentialing decisions are based on multiple criteria related to professional competency, quality of care, and appropriateness by which health or dental services are provided. No Non-Participating Provider shall be denied membership in the Connection Dental Network on the basis of race, ethnic/ national identity, color, creed, ancestry, gender, gender identity, sexual orientation, age, religion, marital status, ethnic/national origin, physical, mental or sensory disability, health status unrelated to the ability to fulfill patient care, or on type of procedure or patient (e.g., Medicaid) in which the Provider specializes.

GEHA/Connection Dental Network
General Policies & Procedures

Network Appeals and Disputes

GEHA/Connection Dental Network (the "Network") has the following processes:

- Network administrative appeals/disputes initiated by Participating Providers related to the performance or interpretation of any of the provisions of the Participating Provider Agreement.
- Network participation appeals/disputes.

I. Network Administrative Appeals/Disputes Initiated by Participating Providers in all States Except North Carolina, New Mexico, and Washington

A. A Participating Provider shall provide the Network with written notice of an administrative dispute within 30 days of the action or decision giving rise to the administrative dispute.

B. The Network and Participating Provider shall use best efforts to resolve the administrative dispute.

C. The Network shall render a written decision regarding the administrative dispute to Participating Provider within 30 days of receipt of the notice of the administrative dispute.

D. Except for Providers in Washington, if the Participating Provider is unsatisfied with the result of the resolution of the administrative dispute as outlined above, the Participating Provider may submit the matter to an arbitrator selected by the American Arbitration Association unless prohibited by applicable law, in which case applicable law shall govern this process. The Network and Participating Provider agree to be bound by the decision of the arbitrator and accept the decision as the final determination. Judgment upon decision of the arbitrator may be entered in any court of competent jurisdiction. The Network and Participating Provider shall each bear its own cost plus one-half the cost of arbitration. Disputes regarding benefits or the payment of benefits for services provided to Covered Enrollees are excluded from coverage under this provision and shall be resolved in accordance with the Payors' appeals processes. Also, issues involving the termination of a Participating Provider from the Network and any appeals or disputes related thereto are covered by the GEHA/Connection Dental Network Credentialing, Recredentialing and Quality Assurance Program Policies and Procedures, which are summarized in Articles III through VI below, and are not covered by this arbitration provision.

E. For Participating Providers located in the State of Washington, if the Participating Provider is unsatisfied with the result of the resolution of the administrative dispute as outlined above, the Participating Provider may submit the matter to non-binding mediation. Such mediation shall be conducted under the Washington Uniform Mediation Act (Chapter 7.07 RCW, or any successor law) unless otherwise agreed by the parties. If any party to the mediation process described above is unsatisfied with the results of this process, it may, by written notice to the other party and to JAMS, submit the dispute to non-binding arbitration before a single arbitrator agreed to by both parties (and if not agreed to within 30 days of the notice of arbitration, then as selected by JAMS). The arbitration shall be conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as otherwise set forth by applicable law. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. The Network and Participating Provider shall share equally the fees of the arbitrator. While the processes described in

this section are not required to the exclusion of judicial remedies, Participating Provider shall exhaust these processes prior to seeking any judicial remedy.

F. The above network administrative appeals/disputes provisions are solely for resolution of Network Participating Provider administrative disputes. Disputes or complaints by, or on behalf of, a Covered Enrollee are subject to the grievance processes of the Payor rather than the Network.

II. Network Administrative Appeals/Disputes Initiated by Participating Providers in North Carolina

A. For Participating Providers located in the State of North Carolina, the process to follow to resolve contract disputes between GEHA, on behalf of the Payor (Carrier), and Participating Providers is:
   1. Participating Provider appeal must be in writing.
      a. Appeal must be submitted within six months from the date of the decision.
      b. Included with the appeals letter shall be the EOB, copy of the actual claim and description of the dispute.
   2. Participating Provider appeal must be sent directly to the Network and not the Payor.
   3. Network shall respond in writing within 90 days of receipt of Participating Provider's appeal.
   4. Network shall respond in writing to insurer (Carrier) and Participating Provider with a letter of decision.

   The Network reserves the right to request additional information deemed necessary in order to settle the dispute in a timely manner. If the Participating Provider disagrees with GEHA's response to its appeal, the dispute shall be resolved by arbitration in accordance with the Participating Provider's agreement with GEHA, unless a different mechanism is required by applicable state law or regulation.

B. If the Participating Provider is unsatisfied with the result of the resolution of the administrative dispute as outlined above, the Participating Provider may submit the matter to an arbitrator selected by the American Arbitration Association unless prohibited by applicable law, in which case applicable law shall govern this process. The Network and Participating Provider agree to be bound by the decision of the arbitrator and accept the decision as the final determination. Judgment upon decision of the arbitrator may be entered in any court of competent jurisdiction. The Network and Participating Provider shall each bear its own cost plus one-half the cost of arbitration. Disputes regarding benefits or the payment of benefits for services provided to Covered Enrollees are excluded from coverage under this provision and shall be resolved in accordance with the Payors' appeals processes. Also, issues involving the termination of a Participating Provider from the Network and any appeals or disputes related thereto are covered by the GEHA/Connection Dental Network Credentialing, Recredentialing and Quality Assurance Program Policies and Procedures, which are summarized in Sections II through V below, and are not covered by this arbitration provision.

C. The above network administrative appeals/disputes provisions are solely for resolution of Network Participating Provider administrative disputes. Disputes or complaints by, or on behalf of, a Covered Enrollee are subject to the grievance processes of the Payor rather than the Network.

III. Network Participation Appeals/Disputes – Network Status Events, Summary Suspensions and Terminations

A. <u>Voluntary Termination</u>.

1. A Participating Provider's participation in the Network and his or her Participating Provider Agreement shall be considered voluntarily terminated by the Participating Provider as described herein as of the date of the occurrence of any of the events described herein or the date the Network discovers the event, whichever is later, and Participating Provider's Provider Agreement shall automatically terminate.
   a. The Participating Provider fails/refuses to submit all required recredentialing information within the 180-day recredentialing process deadline, as required by the Recredentialing Criteria.
   b. The Participating Provider fails/refuses to submit information or clarification(s) requested by the GEHA/ Connection Dental Network Peer Review Committee.
   c. The Participating Provider retires.
   d. The Participating Provider dies.
   e. The Network is unable to locate the Participating Provider following a good faith attempt.
   f. The Participating Provider voluntarily terminates his or her Provider Agreement.
   g. The Provider Agreement is terminated at the end of an initial or renewal term.
2. If a Participating Provider voluntarily terminates his or her Participating Provider Agreement during an adverse action event of the Network, the Provider may not reapply to the Network until after a one-year waiting period from the date the Provider terminated his or her Participating Provider Agreement in accordance with Article VI below. This action shall be final and no Participating Provider shall be entitled to the procedural rights set forth in Articles IV or V below as the result of a voluntary termination by the Participating Provider.

B. Automatic Termination.

1. A Participating Provider's participation in the Network and his or her Participating Provider Agreement shall be automatically terminated as described herein as of the date of the occurrence of the event described herein or the date the Network discovers the event, whichever is later. This action shall be final except when a bona fide dispute exists as to whether the circumstances have occurred.
   a. Occurrences Affecting Licensure: The Participating Provider's license to practice in any state in which the Participating Provider is or will be providing services pursuant to a Participating Provider Agreement is revoked, or suspended, or expired.
   b. Occurrences Affecting Controlled Substances Regulation: The Participating Provider's DEA or other controlled substances license or number in any state in which the Participating Provider is or will be providing services pursuant to a Participating Provider Agreement is revoked, suspended, restricted, or expired.
   c. Conviction of a Crime: The Participating Provider has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, or for any felony or any offense reasonably related to the qualifications, functions or duties of the medical or dental profession, or for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any act involving moral turpitude.
   d. Settlement during Criminal Prosecution: The Participating Provider previously entered into a settlement with a state or federal agency during a criminal prosecution under the laws of any state or of the United States, for any felony or any offense reasonably related to the qualifications, functions or duties of the medical or dental profession, or for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any act involving moral turpitude.
   e. Exclusion from State or Federal Government Programs: The Participating Provider has been excluded, debarred, suspended or otherwise prohibited from participation in any state or federal program including Medicare, Medicaid, TRICARE, the Federal Employees Health Benefits

Program, or any other state or federal program, the Participating Provider is included on the OFAC's Specially Designated Nationals List, or the Participating Provider is included in the EPLS.

f. Loss of Professional Liability Insurance: The Participating Provider fails to have, carry or maintain professional liability insurance as required by GEHA.

2. No Participating Provider shall be entitled to the procedural rights set forth in Articles IV or V below as the result of an automatic termination imposed pursuant to this section.

C. Summary Suspension. If, in the opinion of the Dental Director or Peer Review Committee, a Participating Provider is engaged in behavior or is or may be practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, the Dental Director/Peer Review Committee may summarily suspend, pending investigation, a Participating Provider's participation in the Network. Such investigation shall be conducted by the Network's internal department(s) or designee. Notification will be given to the Participating Provider by signature confirmation mail. Summary suspensions shall be effective immediately and Participating Providers will be removed from directories during the summary suspension period. Due to the nature of summary suspensions, the investigation and notification processes will be handled on an expedited basis, including promptly notifying Participating Provider of the summary suspension by signature confirmation mail. If a Participating Provider is placed in summary suspension status, the action shall be final and binding upon the Participating Provider unless the Participating Provider files a written appeal within 30 days of receipt of the summary suspension letter and pursuant to the procedures set forth in Articles IV and V below; however, if a termination event for that Participating Provider occurs during that summary suspension period, the summary suspension status will end on the date immediately prior to the date of the termination event and no further review or appeals will be considered for the summary suspension.

D. Termination Decisions related to Clinical Reasons.

1. Dental Director or Peer Review Committee may decide to terminate a Participating Provider's participation in the Network for the following clinical reasons:
   a. The Participating Provider's credentials are found to be unsatisfactory by the Peer Review Committee;
   b. Any finding by the Peer Review Committee that the Participating Provider committed professional misconduct or caused a patient harm; or
   b. The Participating Provider has been denied continued participation in the Network due to a Quality Assurance Program occurrence.
2. Notification of terminations related to clinical reasons shall be given to the Participating Provider by signature confirmation mail. Terminations related to clinical issues shall be final and binding upon the Participating Provider unless the Participating Provider files a written notice of appeal within 30 days of receipt of the termination letter and pursuant to the procedures set forth in Articles IV and V below.

E. Termination Decisions related to Non-Clinical Reasons.

1. Dental Director or Peer Review Committee may decide to terminate a Participating Provider's participation in the Network for the following non-clinical reasons, which are reviewed by the Network's legal and/or compliance department personnel in order to make a recommendation to the Dental Director or Peer Review Committee:
   a. Any falsification of any information on the Participating Provider's Credentialing Application or Recredentialing Application or fraud committed on any documentation submitted to the Network or another health care entity; or
   b. Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or

c. Intentional noncompliance with HIPAA laws or regulations.

2. Notification of terminations related to non-clinical issues shall be given to the Participating Provider by signature confirmation mail. Terminations related to non-clinical matters shall be final and binding upon the Participating Provider unless the Participating Provider files a written notice of appeal within 30 days of receipt of the termination letter. Appeals for terminations related to non-clinical matters are not subject to the procedures set forth in Articles IV and V below and shall instead be resolved pursuant to the following procedures:
   a. If a Participating Provider appeals a termination related to a non-clinical matter, the appeal must be submitted to the Network in writing within 30 days of the Participating Provider's receipt of his or her termination letter from the Network.
   b. The Provider Network Manager shall meet with another member of management who was not involved in the initial decision to review the appeal in a fair and impartial manner and, if needed, shall seek advice from legal counsel.
   c. The Network shall render a written decision regarding the appeal within 30 days of receipt of the notice of appeal.
3. Except for Participating Providers in Washington, if the Participating Provider is unsatisfied with the result of the resolution of a non-clinical termination as outlined in this Section E, the Participating Provider may submit the matter to an arbitrator selected by the American Arbitration Association unless prohibited by applicable law, in which case applicable law shall govern this section. The Network and Participating Provider agree to be bound by the decision of the arbitrator and accept the decision as the final determination. Judgment upon decision of the arbitrator may be entered in any court of competent jurisdiction. The Network and Participating Provider shall each bear its own cost plus one-half (1/2) the cost of arbitration.
4. For Washington Participating Provider disputes related to non-clinical termination, if the Participating Provider is unsatisfied with the result of the resolution of the non-clinical termination as outlined in this Section E, the Participating Provider may submit the matter to non-binding mediation. Such mediation shall be conducted under the Washington Uniform Mediation Act (Chapter 7.07 RCW, or any successor law) unless otherwise agreed by the parties. If any party to the mediation process described above is unsatisfied with the results of this process, it may, by written notice to the other party and to JAMS, submit the dispute to non-binding arbitration before a single arbitrator agreed to by both parties (and if not agreed to within 30 days of the notice of arbitration, then as selected by JAMS). The arbitration shall be conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as otherwise set forth by applicable law. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. The Network and Participating Provider shall share equally the fees of the arbitrator. While the processes described in this section are not required to the exclusion of judicial remedies, Participating Provider shall exhaust these processes prior to seeking any judicial remedy.

F. Summary Suspension and Termination Decisions.

1. Adverse summary suspensions and terminations related to clinical reasons may be appealed in accordance with the procedures listed in Articles IV and V below.
2. All summary suspension processes and/or summary suspension appeals shall be discontinued for a Participating Provider upon the occurrence of a termination event. If an automatic termination event or a voluntary termination event occurs, any other termination processes and/or appeals that were already started shall also be discontinued for a Participating Provider.
3. A Participating Provider may not appeal a termination if (1) such Participating Provider was previously summarily suspended based on the same facts and circumstances, and/or (2) such Participating Provider has already exhausted his or her appeals through the Dispute Resolution (first level) and/or Appeal Reconsideration (second level) Committees.

4. Any dispute concerning the summary suspension or an termination related to a clinical reason, which results in suspension or revocation of a Participating Provider's participation in the Network, shall be resolved by the procedures set forth in Articles IV and V below, which shall be the sole and exclusive method to resolve such disputes. The Participating Providers shall be bound by any final decision rendered in accordance with said procedures.
5. When two or more termination events occur simultaneously, the Participating Provider will be terminated on the earliest date of any events.

IV. Network Reconsideration and Appeal Process – Participating Providers in all States Except Washington, New Mexico, and North Carolina

A. Potential Costs of Appeal Reconsideration for Clinical Provider Terminations.

In the event a Participating Provider requests an Appeal Reconsideration (second level appeal) for a Participating Provider termination and the Participating Provider does not prevail in such appeal, the Participating Provider agrees to reimburse the Network for one-half of the Network's actual costs that were necessary to conduct the hearing to the extent permitted under applicable State law. Such actual costs include the service fees, travel expenses and related costs associated with the conduct of the Appeal Reconsideration incurred by the Network, including the fees charged by the members of the Appeal Reconsideration Committee, the Hearing Officer, any persons retained to record and transcribe the proceedings (e.g. court reporter and/or transcriptionist) and, if necessary, any fees charged by a third party for the use of a room to conduct the hearing. The Participating Provider shall pay the Network within 30 days of receipt of the invoice for such costs. A Participating Provider who prevails in an Appeal Reconsideration decision related to a termination shall not be required to reimburse the Network for one-half of the aforementioned costs. Provided however, any party who retains an expert witness to participate in an Appeal Reconsideration Committee meeting to reconsider a Participating Provider termination shall be responsible for payment of all fees related to the services provided by the expert witness. Appeal Reconsideration for summary suspensions do not include a formal hearing and do not require Participating Provider reimbursement.

B. Dispute Resolution Appeals – Summary Suspensions and Provider Terminations related to Clinical Reasons.

1. Notice of Adverse Action. A Participating Provider against whom an adverse action has been made by the Peer Review Committee shall be given notice of the same within 30 days. The notice shall describe the action and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified herein and shall contain this summary of the Participating Provider's rights in such an appeal.
2. Request for Dispute Resolution Appeal. A Participating Provider shall have 30 days after his or her receipt of notice pursuant to the Notice of Averse Action above to file a written request for an appeal. Such request shall be delivered to the Credentialing Quality Assurance Coordinator, or his or her designee. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled and the action shall be final upon the expiration of the 30-day period. Such waiver shall constitute acceptance of the adverse action.
3. Informal Meeting. The Dispute Resolution Committee shall have the ability to overturn a denial and approve a Participating Provider's continued participation in the Network in an informal meeting before a scheduled formal Dispute Resolution Committee meeting is heard.
4. Time and Place of Appeal. The appeal review will take place at a Dispute Resolution Committee Meeting. The Participating Provider will be notified of the time, place and date of the appeal meeting

to be held. This meeting may be held telephonically, so long as all parties can hear and communicate with each other.

5. Dispute Resolution Committee. The appeal shall be heard by the Dispute Resolution Committee. The Dispute Resolution Committee shall be required to objectively consider and decide the case with good faith. A Dispute Resolution Committee Chairperson will be appointed prior to the meeting and will preside over the appeal process and determine the order of the appeal procedure. The meetings of the Dispute Resolution Committee and the files will be considered confidential. The file is not subject to discovery, subpoena or other means of legal compulsion of their release.
6. Conduct of Dispute Resolution Appeal.
   a. During a Dispute Resolution Committee appeal meeting, the following information may be presented to the Dispute Resolution Committee members for examination:
      (i) Participating Provider's file.
      (ii) Adverse action exhibits with Dental Director's, Peer Review Committee Chairperson's, Peer Review Committee Co-Chair's or Peer Review Committee's rationale for denial/termination.
      (iii) Participating Provider appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.
   b. In reaching a decision, the Dispute Resolution Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered in connection with the initial application, any recredentialing documents, and any Quality Assurance Program occurrences.
   c. A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Dispute Resolution Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.
   d. The Dispute Resolution Committee shall be entitled to monitor a Participating Provider for a period of time determined by the Committee and reconvene. During the monitoring period, the Participating Provider's credentials will be reviewed based on the decision made by the Committee.
   e. The Dispute Resolution Committee Chairman, upon a showing of good cause, may grant requests for postponement of the appeal review. The Dispute Resolution Committee may recess the appeal proceedings and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.
   f. The Dispute Resolution Committee may overturn the Peer Review Committee's decision or uphold it.
7. Report of Monitoring Period. If adverse information is received during a Participating Provider's monitoring period or if at the end of a monitoring period, no adverse information was received, a teleconference shall be held with the Dispute Resolution Committee, ensuring that all parties can hear and communicate with each other, and the Committee shall determine the basis for any additional decisions. Within 15 days after the monitoring period review is concluded, a written report of the Committee's decisions and findings shall be placed in the Participating Provider's File.
8. Report of Dispute Resolution Appeal. Within 15 days after the dispute resolution appeal review is concluded, the Credentialing Quality Assurance Coordinator, or his or her designee, shall make a written report of the Dispute Resolution Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Dispute Resolution Committee's decision(s).
9. Effect of Result.

a. If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, notice shall promptly be sent to the Provider involved informing him/her of action taken. Copy of notice will be kept in the Participating Provider's file.
b. If a decision of the Dispute Resolution Committee is favorable to the Participating Provider, such results shall become the final decision of the Dispute Resolution Committee and the matter shall be closed.
c. If the decision of the Dispute Resolution Committee continues to be adverse to the Participating Provider, the Dispute Resolution Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Dispute Resolution Committee and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified in the notice and shall contain this summary of the Participating Provider's rights in such an appeal. A copy of the notice will be kept in the Participating Provider's file.

C. Appeal Reconsiderations – Peer Review Committee Adverse Actions upheld by the Dispute Resolution Committee.

1. Notice of Adverse Action. A Participating Provider against whom a Peer Review Committee Adverse Action has been upheld by the Dispute Resolution Committee shall be given notice of the same within 30 days. The notice shall describe the action from the Dispute Resolution Committee and the reason for it. The notice shall also state that the Participating Provider has the right to request an appeal within the time limits specified in the notice and shall contain this summary of the Participating Provider's rights in such an appeal. For Participating Provider Agreement terminations, the notice shall also advise the Participating Provider of the responsibility to pay the costs specified in Article IV.A above.
2. Request for Appeal Reconsideration. A Participating Provider shall have 30 days after his/her receipt of notice of continued Adverse Action above to file a written request for an appeal. Such request shall be delivered to the Credentialing Quality Assurance Coordinator, or his or her designee, and shall be forwarded to the Appeal Reconsideration Committee. A Participating Provider who fails to request an appeal within the time and in the manner specified herein waives any right to such an appeal and to any arbitration to which he/she might otherwise be entitled and the action shall be final upon the expiration of the 30-day period. Such waiver shall constitute acceptance of the Adverse Action.
3. Informal Meeting. The Appeal Reconsideration Committee shall have the ability to overturn a previous decision in an informal meeting before a scheduled formal appeal is heard.

D. Appeal Reconsiderations – Summary Suspensions Only.

1. Time and Place of Appeal Reconsideration. The Appeal Reconsideration review will take place at an Appeal Reconsideration Committee meeting. The Participating Provider will be notified of the time, place and date of the appeal meeting to be held.
2. Appeal Reconsideration Committee. The appeal shall be heard by the Appeal Reconsideration Committee. The Committee shall be required to objectively consider and decide the case with good faith. The Committee Chairman will reside over the appeal process and determine the order of the appeal procedure. The meetings of the Committee and the files will be considered confidential. The file is not subject to discovery, subpoena or other means of legal compulsion of their release.
3. Conduct of Appeal Reconsideration.
   a. During an Appeal Reconsideration Committee meeting, the following information may be presented to the Appeal Reconsideration Committee members for examination:
      (i) Participating Provider's file.

(ii) Adverse Action exhibits with Dental Director's, Peer Review Committee Chairperson's, Peer Review Committee Co-Chair's or Peer Review Committee's rationale for denial/termination.
(iii) Participating Provider reconsideration and appeal documentation including but not limited to any relevant evidence from Participating Provider or other applicable sources.

b. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file with the Network, and all other information that can be considered in connection with the credentialing, recredentialing or quality assurance program process.
c. A record of the appeal shall be kept with sufficient accuracy such that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Appeal Reconsideration Committee may select the method to be used for making the record, such as electronic recording unit, detailed transcription, or minutes of the proceedings.
d. The Appeal Reconsideration Committee Chairman, upon a showing of good cause, may grant requests for postponement of the appeal review. The Appeal Reconsideration Committee may recess the appeal proceedings and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of a presentation of oral and written evidence, the appeal review shall be concluded.
e. The Appeal Reconsideration Committee may decide to overturn the previous decision to summarily suspend or uphold the previous decision and continue to summarily suspend.

4. Report of Monitoring. If the decision is to continue to summarily suspend, the Network will monitor the Participating Provider's credentials until enough information is received to review the event in full.
5. Report of Decisions. Within 15 days after the appeal reconsideration appeal review is concluded, the Credentialing Quality Assurance Coordinator, or his or her designee, shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's File. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).
6. Effect of Result for Summary Suspensions.
   a. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Provider involved informing him/her of action taken. Copy of notice will be kept in the Participating Provider's File. The Participating Provider will be added back to directories.
   b. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee and the matter shall be closed.
   c. If the decision of the Appeal Reconsideration Committee continues to be adverse to the Participating Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be given to the Participating Provider via signature confirmation mail, within 30 days. The notice shall describe the action from the Appeal Reconsideration Committee and the reason for it.
   d. For summary suspension decisions, the notice shall also state the Network will continue to monitor the Participating Provider's credentials until such time the Network has enough information regarding the summary suspension event to review the matter in full and make a decision about the Participating Provider's network participation status. A copy of the notice will be kept in the Participating Provider's file.

E. Appeal Reconsiderations – Participating Provider Terminations.

1. Notice of Time and Place for Appeal/Hearing for Participating Provider Terminations. At least 30 days prior to the Reconsideration Appeal, the Credentialing Quality Assurance Coordinator shall send the Participating Provider written notice of the time, place and date of the hearing, by Signature Confirmation or overnight mail. The notice of the hearing sent to the Provider shall include a list of witnesses (if any) expected to testify at the appeal in support of the proposed action and a summary of the Participating Provider's rights according to these policies and procedures.
2. Statement of Issues and Events. The notice of appeal/hearing shall contain a concise statement of the Participating Provider's alleged acts or omissions and/or a concise statement of any other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.
3. Conduct of Appeal. The appeal shall be heard by the Appeal Reconsideration Committee.
4. List of Witnesses. In addition to the list of witnesses required in the notice of appeal, at least 10 days prior to the scheduled date for commencement of the appeal, each party shall provide the other with a list of names of the individuals who, as far as then reasonably known, will give testimony or evidence in support of that party at the appeal. Admissibility of testimony to be presented by a witness not so listed shall be at the discretion of the Hearing Officer.
5. Reconsideration Appeal Procedure for Participating Provider Terminations.
    a. Forfeiture of Hearing. A Participating Provider who requests an appeal pursuant to this Article but fails to appear at the hearing without good cause, as determined by the Hearing Officer, shall forfeit his or her rights to such appeal to which he or she might otherwise have been entitled. If the Hearing Officer determines that the failure to appear is without good cause, the decisions shall become final upon the expiration of 30 days from the decision of the Hearing Officer. The Credentialing Quality Assurance Coordinator shall notify the Participating Provider of the decision of the Hearing Officer.
    b. Hearing Officer. The Hearing Officer shall be the presiding officer. He or she shall act to maintain decorum and to assure that all participants in the appeal process are provided a reasonable opportunity to present relevant oral and documentary evidence. He or she shall be entitled to determine the order of procedure during the appeal and shall make all rulings on matters of law, procedure, and the admissibility of evidence.
    c. Representation. The Participating Provider who requested the appeal shall be entitled to be accompanied and represented at the hearing by a member of his or her professional society, and/or by an attorney. The Network may designate an attorney to represent it at the appeal to present the facts in support of its adverse action, and to examine witnesses.
    d. Rights of Parties. During the appeal each party may:
        i. Call, examine and cross-examine witnesses;
        ii. Introduce any relevant evidence, including exhibits;
        iii. Question any witness on any matter relevant to the issues that are the subject of the hearing;
        iv. Impeach any witness;
        v. Offer rebuttal of any evidence;
        vi. Have a record made of the hearing in accordance with Section h. of this Article; and
        vii. Submit a written statement at the close of the hearing.
    e. If a Participating Provider who requested the appeal does not testify in his or own behalf, he or she may be called and examined as if under cross-examination.
    f. Procedure and Evidence. At the appeal, the rules of law relating to examination of witnesses or presentation of evidence need not be strictly enforced, except that oral evidence shall be taken only on oath or affirmation. The Hearing Officer may consider any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs regardless of whether such evidence would be admissible in a court of law. Prior to or during the hearing, any party

may submit memoranda concerning any procedural or factual issue, and such memoranda shall be included in the hearing record.

g. Information Pertinent to Appeal. In reaching a decision, the Appeal Reconsideration Committee shall be entitled to consider any pertinent material contained on file in the Network and information that can be considered pursuant to these Policies and Procedures. The Appeal Reconsideration Committee may at any time take official notice of any generally accepted technical or scientific principles relating to the matter at hand of any facts that may be judicially noticed by Missouri courts. The parties to the appeal shall be informed of the principles or facts to be noticed and the same shall be noted in the hearing record. Any party shall be given the opportunity, upon timely request, to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the Hearing Officer.
h. Burden of Proof. When an appeal relates to an adverse action a Committee Co-Chair shall have the initial obligation to present evidence in support thereof, but the Participating Provider thereafter is responsible for supporting his or her challenge that the adverse action lacks any substantial factual basis or that the basis or the conclusions drawn there from are arbitrary, unreasonable, or capricious.
i. Record of Appeal. A record of the appeal shall be kept of sufficient accuracy that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a decision in the matter. The Hearing Officer shall select the method to be used for making the record, such as a court report, electronic recording unit, detailed transcription, or minutes of the proceedings. Upon written request, the Participating Provider shall be entitled to obtain a copy of the record or use an alternative recording method, at his or her own expense.
j. Postponement. Requests for postponement of an appeal may be granted by the Hearing Officer upon showing of good cause and only if the request is made as soon as is reasonably practical.
k. Presence of Hearing Committee Members and Vote. A majority of the Appeal Reconsideration Committee shall be present at all times during the appeal and deliberations. If a Committee member is absent from any part of the proceedings, the Hearing Officer in his or her discretion may rule that such member be excluded from further participation in the proceedings or decisions of the Committee.
l. Recesses and Adjournment. The Appeal Reconsideration Committee may recess the hearing and reconvene it without additional notice if the Committee deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. When presentation of oral and written evidence is complete, the hearing shall be closed.
m. The Appeal Reconsideration Committee shall deliberate outside the presence of the parties and at such time and in such location as is convenient to the committee. The Hearing Officer shall not participate in the deliberations. Upon conclusion of the Appeal Reconsideration Committee's deliberations, the appeal shall be adjourned.
n. The Appeal Reconsideration Committee may decide to overturn the previous decision to terminate the Participating Provider, uphold the previous decision to terminate a Participating Provider, or suspend the Participating Provider's termination for a specific period of time and reconvene.

6. Report of Suspended Termination Period for Participating Provider Terminations. If adverse information is received during a Participating Provider's suspended termination period, or if a the end of a suspended termination period, no adverse information was received, a teleconference shall be held with the Committee, ensuring that all parties can hear and communicate with each other, and the Committee shall determine the basis for any decision. Within 15 days after the suspended termination review is concluded, a written report of the Committee's decisions and findings shall be placed in the Participating Provider's file.

7. Report of Appeal Review for Participating Provider Terminations. Within 15 days after the appeal review is concluded, the Credentialing Quality Assurance Coordinator, or his or her designee, shall make a written report of the Appeal Reconsideration Committee's findings and decisions in the matter, and such report shall be placed in the Participating Provider's file. The report shall include a statement of the basis for the Appeal Reconsideration Committee's decision(s).

8. Effect of Result for Participating Provider Terminations.
   a. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, notice shall promptly be sent to the Participating Provider involved informing him/her of action taken. Copy of notice will be kept in the Participating Provider's file.
   b. If a decision of the Appeal Reconsideration Committee is favorable to the Participating Provider, such results shall become the final decision of the Appeal Reconsideration Committee and the matter shall be closed.
   c. If the decision of the Appeal Reconsideration Committee continues to be adverse to the Provider, the Appeal Reconsideration Committee shall cause notice of the decision to be sent to the Participating Provider via Signature Confirmation mail. Such results shall become the final decision of the Appeal Reconsideration Committee. Copy of notice to the Participating Provider shall be kept in the Provider's file. Additionally, the Network shall (i) report this adverse action to the National Practitioner Data Bank as required by Federal Law; and (ii) terminate the Participating Provider Agreement with the Provider.

V. Network Participation Appeals/Disputes –Participating Providers in Washington Only [*Source*: WAC 284-43-320(11); WAC 284-43-322; RCW 48.43.055]

Except as otherwise provided in the Participating Provider Agreement, this Article applies to all claims and disputes between Participating Provider and the Network that involve professional conduct or competence, which result in a change in Participating Provider's participation in the Network. Any billing disputes or adverse benefit determinations shall be resolved under the Carrier's policies. While the processes described below are not required to the exclusion of judicial remedies, Participating Provider shall exhaust these processes prior to seeking any judicial remedy.

A. Network Participation First and Second Level Appeal Panels.
   1. Within 30 days of the action giving rise to the Network participation dispute or controversy, the Participating Provider shall submit a written complaint initiating this dispute resolution process to the Network at the address specified below. The complaint shall describe the issue in dispute or controversy and include any supporting documentation relevant to the issues raised.
   2. The Network shall designate a "First Level Appeal Panel" consisting of three individuals, including at least one Participating Provider who is not otherwise involved in Network management and who is a clinical peer of the Participating Provider submitting the complaint. The First Level Appeal Panel shall review the complaint and supporting documentation and render a decision on the matter within 30 days of receiving the complaint. Written notice of the First Level Appeal Panel's dispute determination shall be delivered to the Participating Provider's address on file.
   3. If the Participating Provider is unsatisfied with the result of the First Level Appeal Panel dispute determination, the Participating Provider may have the complaint considered by a "Second Level Appeal Panel" by submitting written notice to the Network within 15 days of receipt of the First Level Appeal Panel's decision. The Second Level Appeal Panel shall be composed of at least three individuals, at least one of which shall be a Participating Provider who is not otherwise involved in Network management and who is a clinical peer of the Participating Provider who submitted the complaint. Further, the Second Level Appeal Panel shall include individuals who were not involved in the decision of the First Level Appeal Panel. The Second Level Appeal Panel shall review the complaint and supporting documentation and render a decision on the matter within 30 days of

receiving the written request for a Second Level Appeal. Written notice of the Second Level Appeal Panel's dispute determination shall be delivered to the Participating Provider's address on file.

B. Alternative Dispute Resolution.
   1. If the Participating Provider is unsatisfied with the result of the Second Level Appeal, Participating Provider may submit the matter to non-binding mediation. Such mediation shall be conducted under the Washington Uniform Mediation Act (Chapter 7.07 RCW, or any successor law) unless otherwise agreed by the parties.
   2. If any party to the mediation process described above is unsatisfied with the results of this process, it may, by written notice to the other party and to JAMS, submit the dispute to non-binding arbitration before a single arbitrator agreed to by both parties (and if not agreed to within 30 days of the notice of arbitration, then as selected by JAMS). The arbitration shall be conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as otherwise set forth by applicable law. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. The Network and Participating Provider shall share equally the fees of the arbitrator.

VI. Network Participation Appeals/Disputes –Participating Providers in New Mexico Only [*Source*: N.M.A.C. 13.10.16.1 – 13.10.16-14]

A. Participating Providers may file a network administrative appeal relative to credentialing deadlines, network adequacy, including participation determinations based upon network composition, including provider qualifications, provider contract construction or compliance, patient standards or access to care, termination, and discrimination. Other appeals such as those related to claim payment amount or timing, claim submission requirements or compliance, utilization management practices, surprise billing reimbursement amount, rate, or timing, operation of the plan, including compliance with any law enforceable by the Superintendent or directive issued by the Superintendent shall be filed directly with the Payor.

B. A Participating Provider shall provide the Network with written notice of an administrative dispute within 90 days of the action or decision giving rise to the administrative dispute. Such appeal can be submitted electronically or manually to the Network Senior Credentialing Representative, Quality by emailing to Brandie.Roth@geha.com or mailing to the Representative at the address of 310 N.E. Mulberry, Lee's Summit, MO 64086.he Network shall send a written acknowledgment of the grievance to the provider within five days of its receipt of the grievance using the provider's preferred communication method.

C. If confirmed in a documented communication between the Network and the provider, the Network and the provider may agree to extend any deadline imposed by this appeals policy.

D. Network may request supplemental information pertinent to the resolution of a grievance from the provider. Any such request shall be made within 10 days of the network's receipt of a grievance and shall require the provider to submit the requested supplemental information within the next 10 days.

E. Network shall respond in writing with regard to the appeal using the provider's preferred method of communication within 45 days of the later of receipt of the grievance, receipt

of supplemental information requested to resolve the grievance, or the due date for submission of any requested supplemental information. The response shall include:

(1) the name(s), title(s), and qualification(s) of each person who participated in the grievance decision;
(2) a statement of issue(s) decided and of the ultimate decision(s);
(3) a clear and complete explanation of the rationale for the decision and a summary of the evidence relied upon to support the decision;
(4) a summary of any proposed remedial action; and
(5) information on the provider's appeal rights.

F. A provider may present oral or documentary evidence to the assigned grievance panel.

G. The assigned grievance panel will be comprised of the Peer Review Committee (PRC) and the Dental Director. The review panel shall be responsible for reviewing and deciding the provider's grievance. If the grievance raises a quality-of-care concern the panel must include a New Mexico-licensed medical professional who practices in the general area of concern. A New Mexico-licensed physician shall be included on a review panel considering complex quality-of-care concerns. No person with a conflict of interest shall participate in a decision to resolve a grievance. Employment with the carrier, standing alone, does not present a conflict of interest.

A provider grievance plan shall allow a provider to submit multiple related grievances simultaneously provided the grievances are not unduly duplicative or repetitive, and for a group of providers to assert a single grievance on behalf of multiple providers.

H. A non-participating provider may submit a grievance relative to credentialing deadlines, network adequacy, including participation determinations based on network composition, network adequacy, and discrimination. The grievance must assert and explain that the network's act or practice directly impacted the non-participating provider or a patient of that provider.

I. In the event a provider files a grievance related to termination, the provider shall be afforded a fair hearing process that provides these minimum rights and protections:

(1) the right of the provider to appear in person at a hearing before the deciding panel;
(2) the right of the provider to present testimonial or documentary evidence at the hearing;
(3) the right of the provider to call witnesses, and cross-examine any witness;
(4) the right of the provider to be represented by an attorney or by any other person of the provider's choice;
(5) the right to an expedited hearing within 14 days of the termination in those instances where the network has not provided advance written notice of termination and the termination could result in imminent and significant harm to a covered person;
(6) a written decision within 20 days after the hearing, contemporaneously delivered via the provider's preferred method carrier of communication; and
(7) if a group of providers is terminated for cause, each provider in the group shall have an individual right to a hearing. However, if any one of the providers in the group submits a grievance relating to the termination, the Network shall provide each similarly

situated provider in the group with a notice of hearing, and each provider who receives such notice shall be bound by the Network's determination subject to any appeal rights.

If a termination is not for cause, the network shall furnish the provider written notice at least 60 days before the effective date of termination. Such notice shall:

(a) be communicated in writing via the format preferred by the provider; and
(b) contain an explanation of the termination.

J. At the request of a provider, the superintendent (NM Department of Insurance) shall conduct an external review of a provider grievance as authorized by this section.

1. Types of grievances subject to appeal**.** The superintendent shall only review a provider grievance that pertains to:

(a) an alleged violation of a law enforceable by the superintendent;
(b) alleged noncompliance with an order of the superintendent; or
(c) a termination based on a provider's alleged failure to comply with a law or order enforceable by the superintendent.

2**.** In the disposition of an appeal, the superintendent may only impose a remedy, penalty, or corrective action authorized by the New Mexico Insurance Code.

3**.** The superintendent shall not review a provider grievance appeal unless the provider has exhausted the network's internal grievance process.

4. A provider appeal of a grievance shall be filed no later than 30 days after the provider receives a response to the grievance, or the deadline for the response, whichever is earlier.

5. The superintendent shall not review a provider grievance appeal that does not contain the following information:

(a) the provider's name, license number, address, daytime telephone number, email address, and any relevant claim number(s);
(b) the name and phone number of the carrier;
(c) certification that the grievance did not pertain to Medicaid or Medicare coverage, excluding Medicare supplement;
(d) a copy of the carrier's written disposition of the grievance, or certification by the provider that the carrier did not issue a written disposition within the time allowed by law;
(e) the date the provider received the carrier's written disposition of the grievance, or the date by which the carrier was required to provide a written disposition if no disposition was received; and

(f) a clear and concise statement of the issue on appeal, and the remedy requested on appeal.

K. Within 45 days of receipt of a provider grievance appeal, the superintendent shall determine whether the appeal is authorized by this section and otherwise reviewable. The superintendent may request supplemental information from the provider or Network to so determine. The time between any such request and the delivery of the requested information by the superintendent shall be excluded from the 45-day deadline imposed by this section.

L. If the superintendent determines that an appeal is not authorized or reviewable, the superintendent shall issue an order dismissing the appeal and stating the reason for dismissal.

M. If the superintendent determines that an appeal is authorized and reviewable, the superintendent shall schedule either a formal or an informal hearing pursuant to the superintendent's rules, as appropriate to the issues, facts and circumstances presented in the appeal. The order setting the hearing shall authorize a designated hearing officer to take or authorize any action authorized by law to resolve the appeal.

N. The superintendent may order the parties to an appeal to participate in formal or informal settlement discussions focused on resolving the issue on appeal. If all parties to an appeal consent, the assigned hearing officer may facilitate the settlement discussions without being disqualified from issuing a recommended decision on appeal.

O. Upon an express finding of good cause, the superintendent may waive any deadline, format or process requirement imposed by this section.

P**.** No person shall be subject to retaliatory action by a carrier for submitting or supporting a grievance or appeal.

Q. The Network shall maintain a detailed log of provider grievances and their resolutions for a period of no less than five years. The Network shall make the log available to the superintendent upon request.

VII. Ability to Reapply to the Network

If any action under these Policies and Procedures is deemed final and is an adverse action with respect to a Participating Provider, or if a Participating Provider is terminated from the Network for contract default, or if a Participating Provider voluntarily terminates his or her Participating Provider Agreement during an adverse action event, the Participating Provider may not reapply to the Network until after a one-year waiting period from the date the Participating Provider is notified of the final action. The Participating Provider shall not be permitted to reapply prior to the end of such one-year period.

VIII. Submitting Appeals, Disputes and/or Complaints

Connection Dental Network
All Connection Dental Network Participating Provider appeals, disputes or complaints (with the exceptions of billing or adverse benefit determination disputes and/or disputes or complaints by, or on behalf of, a Covered Enrollee) should be sent to:

Connection Dental Network
Attn: CD Supervisor
P.O. Box 6707
Lee's Summit, MO 64064-6707

Phone: 800.505.8880, option 3
Fax: 816.257.4439
Online: connectiondental.com

You may give us your feedback or input by completing an online Participating Provider Satisfaction Evaluation at connectiondental.com.

Other Payors

Billing or adverse benefit determination appeals, disputes or complaints should be sent directly to the Payor. For Payors other than GEHA, please see the member's Identification Card. To obtain specific information about Payors other than GEHA, please call GEHA's Client Relations department at 877.277.6872, and you will be directed to the Payor's toll free telephone number, email address, or website.

GEHA Health and Dental Plans

GEHA uses its Connection Dental Network Participating Providers as PPO providers for its federal health and dental plans. State law is specifically preempted with regard to the operation of GEHA's health and dental plans. GEHA health plan members are participants in the Federal Employees Health Benefits Program, and billing and benefit matters for such participants are resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM. Billing and benefit matters for participants in the GEHA Connection Dental Federal and Connection Dental *Plus* plans are resolved in accordance with the procedures outlined in the applicable benefit brochures. The benefit brochures for the GEHA dental plans are at geha.com/Plans-and-Benefits/Dental-Plans.

GEHA Health and Dental Plans billing and/or benefit disputes may be sent to:

GEHA Health Plans
P.O. Box 4665
Independence, MO 64051-4665
800.821.6136

GEHA Connection Dental Federal
P.O. Box 21542
Eagan, MN 55121

GEHA Connection Dental Plus
P.O. Box 21542
Eagan, MN 55121

Connection Dental Network
Policy No. 2
Updated 1/17

Composition of Network

GEHA shall administer and, in its sole discretion, determine the composition of the Connection Dental Network and any subset thereof. In the event a provider is contracted through more than one Participating Provider Agreement, GEHA shall, in its sole discretion, determine the contract with which the provider shall be contracted. GEHA can approve or disapprove of new providers becoming Participating Providers. In the event a Participating Provider fails to satisfy any of the requirements of an applicable Participating Provider Agreement or if a Participating Provider is terminated pursuant to a Participating Provider Agreement, said Participating Provider must cease providing Covered Services under the Participating Provider Agreement upon written notice from GEHA.

Connection Dental Network
Policy No. 3
Updated 12/20

GEHA Policies & Procedures
Connection Dental Network

1. Government Employees Health Association, Inc. (GEHA) owns and operates the Connection Dental Network, a non-risk bearing PPO dental network. GEHA reserves the right to determine the composition of the Connection Dental Network and any subset thereof. GEHA will comply with all applicable state and federal laws with regard to the operation of the Connection Dental Network.

2. GEHA utilizes the Connection Dental Network to provide a PPO option for its own dental insurance products, Connection Dental *Plus* and GEHA Connection Dental Federal, and also directs members of the GEHA health plan to its participating dentists. Connection Dental *Plus* is a comprehensive dental product that is available to all federal employees as a method of supplementing their limited dental coverage through their medical plan. GEHA Connection Dental Federal is one of the dental plans available to all federal employees through the Federal Employee Dental and Vision Benefits Enhancement Program (FEDVIP) program.

3. The Connection Dental Network is leased to other Payors at the discretion of GEHA. A list of other Payors that utilize the Connection Dental Network is available upon request and is also available electronically by accessing the Resource tab at https://www.connectiondental.com/. At any time, a Provider may call or email Connection Dental to request that he/she be removed from the leasing arrangement for one or more specific Payors, When necessary, supervisor approval will be required. Depending on the required processing timeframes, the change may not be effective immediately. Participating locations for Participating Providers in the Connection Dental Network are initially determined by the demographic information submitted to the network by the provider on his or her credentialing application. Once a provider has been approved to participate in the network, all locations for the Participating Provider shall be considered in-network for that provider where name and address or name match Tax Identification Number. Participating Providers must notify the network of any additional location(s) that will be using the Participating Provider's Tax Identification Number within 10 days of adding the additional location or moving to a new location.

4. GEHA has the right and authority to negotiate contracts with other Payors on behalf of the Connection Dental Network and each of the network's Participating Providers.

5. GEHA has the right and authority to give and/or receive Payor notices on behalf of the Connection Dental Network and each of the network's Participating Providers.

6. If GEHA cancels or terminates a Payor agreement, termination of that Payor will simultaneously occur for all Participating Providers in the Connection Dental Network, but will not affect the Participating Provider Agreement with regard to other Payor agreements.

7. GEHA, for Connection Dental *Plus* and GEHA Connection Dental Federal, and each Payor with whom GEHA contracts, will use best efforts to provide identification cards to their members that include the Connection Dental logo and claim filing and eligibility information.

8. All Participating Providers are required to comply with the credentialing, recredentialing and quality assurance programs of GEHA/Connection Dental Network.

9. All Participating Providers must participate in and comply with the following programs of GEHA and/or other Payors: quality assurance, cost utilization, utilization management, and precertification programs, if applicable.

10. Participating Providers are not required to extend a discount for services not listed on the Connection Dental Fee Schedule and may bill members for the full amount due for such services.

11. Participating Providers may not charge an amount greater than the Fee Schedule allowable amount for any item or service listed on the Fee Schedule, even if the item or service is considered non-covered as a benefit, unless otherwise permitted by applicable law or regulation.

12. If a Covered Enrollee transfers his or her care to another provider, it is the responsibility of the Participating Provider to transfer dental records associated with the Covered Enrollee to the new provider.

13. Participating Providers are required to notify the Connection Dental Network in the event of any change to the provider's participation status, name, address, telephone number or tax identification number. Participating Providers must also notify the network if the Participating Provider closes his or her practice to new members. If a Participating Provider moves to another zip code area after initial contracting, the Fee Schedule will change to that applicable to the new zip code area in which the Participating Provider will be practicing. If a Participating Provider moves or closes his or her office after initial contracting and does not notify GEHA in writing, GEHA will make a good faith attempt to locate the Participating Provider; however, if GEHA is unable to locate the Participating Provider, the Participating Provider Agreement may be terminated effective immediately by GEHA without written notice or cause unless prohibited by law.

14. Participating Provider changes (e.g., Tax Identification Numbers) and notifications of new locations are updated in our system as of the date the provider gives us or the date of receipt, whichever is later. When participating providers notify us of terminated locations, the locations are terminated on the last day of the month of the date we process the information or the actual termination date, whichever is later. When we receive questions from Payors about whether provider locations should be considered in-network, we call providers to verify the information to ensure claims are processed correctly. Providers may terminate Participating Provider Agreements in accordance with the termination provisions in the contracts.

15. Questions about benefits, the payment or appeal of benefits, or to identify dental care services that are provided by the Payor should be directed to the applicable Payor. The Payor's telephone number is available on the member identification cards.

16. Questions regarding the Participating Provider Agreement or Connection Dental Network should be directed to 800.505.8880.

17. GEHA may amend the Connection Dental Participating Provider Agreements by providing written notice to its Participating Providers. Such amendment shall be deemed accepted by the Participating Provider unless Participating Provider provides written notice of nonacceptance to GEHA within 30 days of Participating Provider's receipt of such amendment unless another timeframe is governed by law. Notwithstanding any other provisions of the Agreement, the Participating Provider Agreements shall automatically be amended to comply with changes in state or federal law.

18. Except for website notices, for contract notices provided pursuant to Group Participating Provider Agreements, notices shall be written and personally delivered, effective on delivery, or sent by United States mail, postage prepaid, effective on the fifth (5th) day following the date deposited in the mail, addressed to the parties listed under the signature block of the Participating Provider Agreement, or to any other name or address specified in writing by such party. Contract notices for individually contracted Participating Providers may be sent to any active practice location for a Participating Provider. Website notices will be posted on GEHA's Connection Dental Network website at connectiondental.com.

19. These policies and procedures are subject to change without notification. Changes in state and/or federal laws that are applicable to the GEHA Participating Provider Agreements or the Connection Dental Network are hereby incorporated into these policies and procedures.

20. Services must be necessary and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a Participating Provider unless the Participating Provider notifies the patient of his or her liability prior to treatment and the patient chooses to receive the treatment. Participating Providers shall document such notification in their records.

21. Participating Providers in the Connection Dental Network must make best efforts to bill the insurance company(ies) on behalf of his or her patients.

22. Participating Providers in the Connection Dental Network who provide care or treatment to Medicare or Medicare Advantage Covered Enrollees must comply with and all applicable Medicare laws, regulations, and CMS instructions and agree that any services provided by Participating Provider or his/her subcontractors to Covered Enrollees will be consistent with and comply with Medicare Advantage Organizations' contractual obligations. These obligations are listed below and on the Connection Dental website, http://www.connectiondental.com/ under the Resource/Connection Dental Payor Documents tab.

a. comply with all applicable Federal laws and regulations, including, but not limited to: Federal Criminal law; the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act);
b. acknowledge that Medicare Advantage Organizations shall oversee and is/are accountable to CMS for the functions and responsibilities described in the Medicare Advantage regulatory standards. Further, Participating Provider acknowledges that Medicare Advantage Organizations may only delegate such functions and responsibilities in a manner consistent with the standards set forth under 42 CFR §422.504(i)(4);
c. acknowledge that the Department of Health and Human Services, the Comptroller General, or their designees have the right to audit, evaluate, or inspect any books, contracts, computer or other electronic systems (including medical records and documentation of first tier, downstream, and entities;
d. related to CMS's contract with Medicare Advantage Organizations), patient care documentation, and other records of Participating Providers, subcontractors or transferees involving transactions related to the Medicare Advantage program through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4) or other applicable law, whichever is later. Dentist agrees to provide all information necessary for Medicare Advantage Organizations to meet data reporting and submission obligations to CMS and data necessary for the Medicare Advantage Organizations to

meet reporting requirements under 42 CFR §422.516 and §422.310. Participating Provider must also make available Participating Provider's office, premises, physical facilities and equipment, records relating to patients, and any additional relevant information that CMS may require.;

e. maintain related records for then (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4) or other applicable period, whichever is later;
f. maintain accurate and complete dental records and other information with respect to Covered Enrollees in an accurate and timely manner and ensure timely access by Covered Enrollees to the records and information that pertain to them;
g. ensure that services are provided in a culturally competent manner to all Covered Enrollees, including those with limited English proficiency, limited reading skills or hearing incapacity, and those with diverse cultural and ethnic backgrounds;
h. acknowledge that Medicare Advantage Organizations are prohibited from contracting with and paying providers who are included in the CMS Preclusion list; further upon the expiration of the 60-day notice period specified in 42 CFR 422.222, the provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per § 422.504(g)(1)(iv); and the provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider and the beneficiary will have already received notification of the preclusion; and
i. for all Covered Enrollees eligible for both Medicare and Medicaid, Participating Provider agrees that: Covered Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts; cost sharing will not be imposed that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Further, Participating Provider will:
   (1) accept the Medicare Advantage plan payment as payment in full, or
   (2) bill the appropriate State source.

Connection Dental Network's provider payment policies
Participating Provider Agreement

GEHA and Payors shall use best efforts to make all payments due to the Participating Provider within thirty (30) days of receipt of a clean claim. GEHA shall not be an insurer, guarantor, or underwriter of the responsibility or liability of any other Payor to provide payments pursuant to any other Payor's plan.

The Participating Provider agrees that he/she will accept the lesser of the Fee Schedule amounts for the procedures listed on the Fee Schedule or the Participating Provider's usual billed charges as payment in full and not balance bill Covered Enrollees for any amount in excess of the lesser of the Fee Schedule amounts for the procedures listed or the Participating Provider's usual billed charges. The Participating Provider shall be required to accept the Fee Schedule amount for all services listed on the Fee Schedule unless prohibited by law. Participating Provider shall also be required to bill Covered Enrollees for any coinsurance, copayment or deductible as permitted by a particular plan covered by this Agreement.

The Participating Provider agrees that he/she will agree that if a service is not listed on the Fee Schedule, no discount shall be taken, and the Participating Provider will be reimbursed based on the plan and the total billed charges. Nothing shall prohibit Participating Provider from pursuing any recourse against the insuring corporation, Payor or their successors.

The Participating Provider agrees that he/she will cooperate with and follow credentialing and appeal procedures established by GEHA and Payors.

The Participating Provider agrees that he/she will request, accept and maintain written assignment of benefits.

The Participating Provider agrees that he/she will cooperate, participate in and comply with all policies and procedures of GEHA or any Payor, none of which shall override the professional or ethical responsibility of the Participating Provider or interfere with the Participating Provider's ability to provide information or assistance to their patients, and that are provided on GEHA's website at connectiondental.com or provided to Participating Provider by GEHA or Payors in accordance with applicable law.

Participating Provides are not required to indemnify Payors for any expenses or liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against the Payor based on the Payor's management decisions, utilization review provisions or other policies, guidelines or actions. Nothing in this section, however, shall in any way affect or limit Participating Provider's right or obligation to collect deductibles, coinsurance, or copayments, as specifically provided in the plan, or fees for non-covered services delivered to Covered Enrollees. This provision shall survive termination of this Agreement for services rendered prior to the termination of this Agreement, regardless of the cause of the termination.

GEHA is not liable for any claims for services provided by a Participating Provider to a Covered Enrollee who is entitled to benefits payable under any other plan other than covered services under the GEHA Plan, which operates pursuant to the FEHBP, Connection Dental *Plus* or GEHA Connection Dental Federal.

Disputes regarding benefits or the payment of benefits for services provided to Covered Enrollees are excluded from Arbitration and shall be resolved in accordance with the Payors' appeals processes.

[Click below to select your State's laws.]

Alabama State Specific Policies & Procedures

Alaska State Specific Policies & Procedures

Arizona State Specific Policies & Procedures

Arkansas State Specific Policies & Procedures

California State Specific Policies & Procedures

Colorado State Specific Policies & Procedures

Connecticut State Specific Policies & Procedures

Delaware State Specific Policies & Procedures

District of Columbia State Specific Policies & Procedures

Florida State Specific Policies & Procedures

Georgia State Specific Policies & Procedures

Hawaii State Specific Policies & Procedures

Idaho State Specific Policies & Procedures

Illinois State Specific Policies & Procedures

Indiana State Specific Policies & Procedures

Iowa State Specific Policies & Procedures

Kansas State Specific Policies & Procedures

Kentucky State Specific Policies & Procedures

Louisiana State Specific Policies & Procedures

Maine State Specific Policies & Procedures

Maryland State Specific Policies & Procedures

Massachusetts State Specific Policies & Procedures

Michigan State Specific Policies & Procedures

Minnesota State Specific Policies & Procedures

Mississippi State Specific Policies & Procedures

Missouri State Specific Policies & Procedures

Montana State Specific Policies & Procedures

Nebraska State Specific Policies & Procedures

Nevada State Specific Policies & Procedures

New Hampshire State Specific Policies & Procedures

New Jersey State Specific Policies & Procedures

New Mexico State Specific Policies & Procedures

New York State Specific Policies & Procedures

North Carolina State Specific Policies & Procedures

North Dakota State Specific Policies & Procedures

Ohio State Specific Policies & Procedures

Oklahoma State Specific Policies & Procedures

Oregon State Specific Policies & Procedures

Pennsylvania State Specific Policies & Procedures

Rhode Island State Specific Policies & Procedures

South Carolina State Specific Policies & Procedures

South Dakota State Specific Policies & Procedures

Tennessee State Specific Policies & Procedures

Texas State Specific Policies & Procedures

Utah State Specific Policies & Procedures

Vermont State Specific Policies & Procedures

Virginia State Specific Policies & Procedures

Washington State Specific Policies & Procedures

West Virginia State Specific Policies & Procedures

Wisconsin State Specific Policies & Procedures

Wyoming State Specific Policies & Procedures