GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Florida

The below policies and procedures are in addition to the contractual requirements and the GEHA Policies & Procedures for the CONNECTION Dental Network. In the event the below terms conflict with the contractual requirements or the GEHA Policies & Procedures for the CONNECTION Dental Network, the terms below shall supersede.

Appeal and Grievance Procedures
Please see Network Appeals/Grievances Policies and Procedures.

Terminations Procedures
When a contract between an organization and a treating provider is terminated for any reason other than for cause, each party shall allow subscribers for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the subscriber was receiving care at the time of the termination, until the subscriber selects another treating provider, or during the next open enrollment period offered by the organization, whichever is longer, but not longer than 6 months after termination of the contract. Each party to the terminated contract shall allow a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subsection, the organization and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.
F.S.A. § 641.51

Subject to applicable continuity-of-care laws, the right of a third party to exercise the rights and responsibilities of a contracting entity under a Participating Provider Agreement terminates on the day following the termination of the Participating Provider's contract with GEHA.
F.S.A. § 627.64731

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
Any employer, group, or organization that pays or contributes to the premium of a group health insurance plan or dental service plan corporation which provides dental coverage only upon the condition that services be rendered by an exclusive list of dentists or groups of dentists shall provide an alternative to enable the insured to have a free choice of dentist. The employer, group, or organization shall pay or contribute an equal dollar amount toward either alternative elected by the insured. The provisions of this section do not require the commingling of costs and claims experience between the two alternative plans. Each insurer or dental service plan corporation in this state that transacts group insurance or provides prepaid health care which includes dental care only upon the condition that services be rendered by an exclusive list of dentists or groups of dentists shall advise the employer, group, or organization of the requirements of this subsection during the course of marketing or renewal of such health care policies.

F.S.A. § 627.6577

A group practice or sole provider may not enter into, extend or renew any contract with a practice management company that provides any financial incentives, directly or indirectly, based on an increase in outside referrals for diagnostic imaging services from any group or sole provider managed by the same practice management company. The group practice or sole provider accepting outside referrals for diagnostic imaging services must bill for both the professional and technical component of the service on behalf of the patient, and no portion of the payment, or any type of consideration, either directly or indirectly, may be shared with the referring physician.
F.S.A. § 456.053

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
All claims for overpayment must be submitted to a provider within 30 months after the health insurer's payment of the claim. A provider must pay, deny, or contest the health insurer's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.
F.S.A. § 627.6131

All claims for underpayment from a provider must be submitted to the insurer within 12 months after the health insurer's payment of the claim. A claim for underpayment may not be permitted beyond 12 months after the health insurer's payment of a claim.
F.S.A. § 627.6131

A contracting entity that leases, rents, or otherwise grants access to a participating provider's health care services must ensure that an explanation of benefits or remittance advice furnished to the participating provider that delivers health care services under the health care contract identifies the contractual source of any applicable discount.
F.S.A. § 627.64731

The U.S. Office of Personnel Management (OPM) has contracting authority for both the Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Federal Employees Health Benefits (FEHB) plans. GEHA is contracted with the OPM for both its Connection Dental Federal FEDVIP plan and GEHA Health FEHB plans.
5 U.S.C.A. § 8902

The terms of GEHA’s contracts with the OPM which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relate to health insurance or plans.
5 U.S.C.A. §8902(m)(1)

The GEHA Health plan, like other FEHB medical plans, offers limited dental coverage to its members and, by law, the FEHB plans are the first Payor (before FEDVIP plans) for dental coverage provided to FEDVIP Covered Enrollees.
5 U.S.C.A. § 8954(e)

To ensure consistency in the coordination of benefits among the FEDVIP carriers, the OPM has amended its contract with GEHA to state that when treating a FEDVIP Covered Enrollee, the Plan Allowance (which, for

Connection Dental Federal is defined as the amount we allow for a specific procedure) is the maximum amount that may be charged to a FEDVIP Covered Enrollee. Neither GEHA nor any FEDVIP Covered Enrollee shall be held responsible or liable for any amounts greater than the FEDVIP allowable amount for services rendered by a Participating Provider to a FEDVIP Covered Enrollee. FEDVIP Covered Enrollees cannot be billed the difference between FEDVIP Plan Allowance and the first Payor's allowance, when the first Payor's allowance is greater than the FEDVIP allowable amount. Thus, FEDVIP Covered Enrollees will only be responsible for payment of the balance of the FEDVIP Plan Allowance minus all payments made by the first Payor and GEHA. FEDVIP Covered Enrollees and GEHA will not be responsible for increased out-of-pocket costs when Covered Enrollees utilize the services of a Connection Dental Participating Provider that also participates in another Payor's PPO network. This is applicable to GEHA Connection Dental Federal and the GEHA Health Plan.
FEDVIP Technical Guidance, Amendment 0005

Provider-Patient Relationship

GEHA does not control the selection of a course of treatment for a patient, the procedures or materials to be used as part of such course of treatment, or the manner in which such course of treatment is carried out by the Participating Provider. GEHA also does not control the patient records, policies and decisions relating to pricing, credit, refunds, warranties and advertising or decisions relating to office personnel and hours of practice of the Participating Provider.
F.S.A. § 466.0285

GEHA will not retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to any provider for reporting in good faith a violation of law to an agency, hospital, medical staff or other interested party or government agency; a physician who refuses to transfer a patient if the physician determines, within a reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the patient; or a physician who effectuates the transfer of a patient if the physician determines, within a reasonable medical probability, that failing to transfer the patient will create a medical hazard to the patient.
F.S.A. § 395.1041

Required Content in Contract

The Participating Provider Agreements apply to network rental arrangements, and one purpose of the contract is to grant access to the services of the Participating Providers to other Payors or entities, which may include a Payor; a third-party administrator or other entity responsible for administering claims on behalf of a payor; a preferred provider organization or preferred provider network; or an entity that provides electronic claims transport between GEHA and a Payor or third-party administrator.
F.S.A. § 627.64731

All third parties that have been given access to a Participating Provider's discounted rate must comply with the Participating Provider Agreements, including all requirements to encourage access to the Participating Provider, and pay the provider pursuant to the rates of payment and methodology set forth in the contract, unless otherwise agreed to by the Participating Provider. Participating Providers may obtain a listing of the third parties that have access to their health care services by calling (800) 505-8880.
F.S.A. § 627.64731

These policies and procedures are subject to change without notification as permitted by law. Any 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.

Please note: Government Employees Health Association, Inc.'s Federal Employee Health Benefits Plans are not subject to state law. GEHA owns and operates the CONNECTION Dental Network, which is a non-risk

bearing PPO network. The above policies and procedures may or may not be applicable to the CONNECTION Dental Network, depending on whether the network is included within the state-specific definitions that are applicable to state laws, rules and regulations.

GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be 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.

Last modified September 12, 2017.