GEHA Policies & Procedures
Connection Dental Network/PPO USA Network
State Specific Policies & Procedures - State of Illinois

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

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

Termination Procedures
To terminate the Participating Provider Agreement, no less than 30 days prior written notice by either party is required. The Participating Provider Agreement may be terminated immediately for cause.

"Health care plans" must give at least 60 days notice of nonrenewal or termination of a provider to the provider and to plan enrollees. SB 251, Section 1. Notice of termination given to providers must include a name and address to which an enrollee or provider may direct comments and concerns related to the termination or nonrenewal. If a provider has been disciplined by the State licensing board, a plan may provide immediate notice of termination without 60 days notice. This provision does not apply to network contracts with health plans that provide only dental service coverage.

If a provider in a health plan network stays in the area but leaves the network for reasons other than termination of a contract and if there were no issues involving imminent harm to a patient or a final disciplinary action by a State licensing board, the health plan must allow the enrollee to continue ongoing treatment with that physician. Treatment can continue for a period of up to 90 days from the date of the notice of the termination from the health plan to the enrollee or through post-partum care if the enrollee has entered into the third trimester of pregnancy at the time of the provider's disaffiliation from the health care plan. In order to continue treatment during this period, the provider must agree to continue to accept payment form the plan at the contractual rates, and adhere to the quality assessment requirements and policies and procedures of the plan.

New enrollees of a health plan are similarly able to continue ongoing treatments of care with providers that are not a part of the health care plan network. Treatment can continue for a period of up to 90 days after enrollment of the enrollee or through post-partum care if the enrollee has entered the third trimester of pregnancy as of the effective date of enrollment. The out-of-network provider must agree to accept payment from the plan at the contractual rates, and adhere to the quality assessment requirements and policies and procedures of the plan.

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures

There must be written policies and procedures for determining when a network is closed to new providers desiring to enter the network, as well as policies and procedures for adding providers to a closed network when openings become available due to attrition and expansion.

Subscribers of dental service plan corporations must be allowed to choose any participating dentists, as long as the dentist agrees to accept the subscriber as a patient. Any dentist practicing or residing in the area in which the dental service plan corporation operates is eligible to become a participating dentist. 215 I.L.C.S. 110/19.

There is an any willing pharmacy requirement that states a health plan is required to establish terms and conditions that must be met by pharmacy providers desiring to contract with the health care plan. A health care plan must not refuse to contract with a pharmacy provider that meets the terms and conditions established.

A health care provider must be given a copy of the proposed provider contract, including any exhibits and attachments that are to be attached to the provider contract. Within 35 days of a written request from the provider, the offering entity must provide the provider with an opportunity to review and obtain a copy of the following: a specialty-specific fee schedule sample based on a minimum of the 50 highest volume fee schedule codes with the rates applicable to the provider, the network provider administration manual, and a summary capitation schedule, if payment is made on a capitation basis. If 50 fee codes do not exist for a particular specialty, the health care provider must be given the opportunity to review or obtain a copy of a fee schedule sample with the codes applicable to that particular specialty. The entity offering the provider contract can substitute the fee schedule sample with a document providing reference to the information needed to calculate the fee schedule that is available to the public at no charge and the percentage or conversion factor at which the entity sets its rates. The provider must be given at least 30 days to review the information provided by the entity offering the contract, which begins upon receipt of the information by the provider. However, nothing prevents the provider from signing a contract prior to the expiration of this 30 day review period. Information given by the entity offering the contract is considered to be confidential, proprietary and trade secret information that must be protected pursuant to Illinois law. HB 1074

Quality of Care Procedures

Participating Providers shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons who are patients of Participating Provider, on a 24 hours per day, 7 days per week basis. Utilization of an answering machine or answering service shall be considered acceptable arrangements during non-working hours.

If Participating Provider finds it medically necessary to refer a Covered Person to an out-of-network provider, the Payor shall ensure that the Covered Person referred shall incur no greater out-of-pocket liability than had the Covered Person received services from a Participating Provider. However, if the Covered Person willingly chooses to access an out-of-network provider, contractual requirements for non-participating providers will apply. 50 Ill. Adm. Code 2051.280(b)

Claims Procedures

Insurers are required to pay clean claims within 30 days of presentation of the claim. Chapter 215 §5/368a.

Increases or decreases to fee schedule amounts must be provided to the providers no later than 35 days after the effective date of the changes, unless the changes are specified in the provider contract and the provider is able to calculate the changed rates based upon information in the contract. HB 1074.

Insurers must provide health care providers with a remittance advice, with must include an explanation of a recoupment or offset taken by the insurer, if any. The remittance advice must identify the patient, the date of service, the service code or description, the recoupment amount and the reason for such recoupment amount. HB 1074.

Covered Persons are not responsible for any reasonable costs associated with medical record transmission or duplication in order to have a claim adjudicated. 50 Ill. Adm. Code 2051.310(c)

Covered Persons shall receive emergency care coverage such that payment for this coverage is not dependent upon whether the services are performed by a preferred or non-preferred provider and the coverage shall be at the same benefit level as if the service or treatment had been rendered by a preferred provider. For purposes of this section,"the same benefit level" means that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider. 50 Ill. Adm. Code 2051.310(a)(6)(J)

Provider-Patient Relationship
A dental service plan corporation may not impose any restrictions on the methods of diagnosis or treatment. 215 I.L.C.S. 110/19.

No health care plan or its subcontracts may prohibit or discourage health care providers by contract or policy from discussing any health care services and health care providers, utilization review and quality assurance policies, terms and conditions of plans and plan policy with enrollees, prospective enrollees, providers, or the public.

Plans may not retaliate against a physician or other health care provider that advocates for patients.

Required Content in Contract
GEHA and Participating Provider agree that the rights and responsibilities under this Agreement cannot be sold, leased, or assigned to another insurer without providing notice of the assignment or lease within 30 days after the assignment or lease to the contracting dentist. 215 I.L.C.S.5/355.4

The PPO identification card must contain the administrator’s name and a toll-free telephone number.

In any case in which a Covered Person has made a good faith effort to utilize Participating Providers for a covered service and it is determined that the Payor does not have the appropriate Participating Providers due to insufficient number, type or distance, the Payor shall ensure, directly or indirectly, by terms contained in the Payor contract, that Covered Person will be provided the covered service at no greater cost to the Covered Person than if the service had been provided by a Participating Provider. However, if the Covered Person willfully chooses to access an out-of-network provider for health care services available through the Payor’s panel of Participating Providers, the contractual requirements for out-of-network provider reimbursements will apply. 50 Ill. Adm. Code 2051.310(a)(6)(H)

The provider agrees that in no event including, but not limited to, nonpayment by the organization of amounts due the provider under this contract, insolvency of the organization or any breach of this contract by the organization, shall the provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from or have any recourse against the enrollee, persons acting on the enrollee's behalf (other than the organization), the employer or group contract holder for services provided pursuant to this contract except for the payment of applicable copayments for services covered by the organization or fees for services not covered by the organization. The requirements of this clause shall survive any termination of this contract for services rendered prior to

such termination, regardless of the cause of such termination. The organization's enrollees shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the provider and the enrollee or persons acting on the enrollee's behalf (other than the organization). 215 ILCS 130

No health care plan or its subcontractors can attempt to transfer to a health care provider by indemnification, hold harmless, or contribution requirements concerning any liability relating to activities, actions, or omissions of the health care plan or its officers, employees, or agents. Nothing in this Section shall relieve any person or health care provider from the liability for his, her, or its own negligence in the performance of his, her or its duties arising from treatment of a patient.

These policies and procedures are subject to change without notification as permitted by law. Any change in state and/or federal laws that are applicable to the GEHA Participating Provider Agreements or the CONNECTION Dental Network or PPO USA Network are hereby incorporated into these policies and procedures.

Please note: Government Employees Hospital Association, Inc.'s Federal Employee Health Benefits Plans are not subject to state law. GEHA owns and operates PPO USA Network and CONNECTION Dental Network, which are non-risk bearing PPOs. The above policies and procedures may or may not be applicable to the PPO USA Network or CONNECTION Dental Network, depending on whether either 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.

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