



**GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Kansas**

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

No state-specific requirements.

Dispute Resolution Process

Please see Network Appeals/Grievances.

Network Participation Procedures

Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the healing arts act of this state, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such services are performed by an optometrist, dentist or podiatrist acting within the lawful scope of their license.

K.S.A. 40-2,100

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

Within 30 days after receipt of any claim, and amendments thereto, any insurer issuing a policy of accident and sickness insurance shall pay a clean claim for reimbursement in accordance with this section or send a written or electronic notice acknowledging receipt of and the status of the claim. Such notice shall include the date such claim was received by the insurer and state that: (1) The insurer refuses to reimburse all or part of the claim and specify each reason for denial; or (2) additional information is necessary to determine if all or any part of the claim will be reimbursed and what specific additional information is necessary. If any insurer issuing a policy of accident and sickness insurance fails to comply, such insurer shall pay interest at the rate of 1% per month on the amount of the claim that remains unpaid 30 days after the receipt of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest. After receiving a request for additional information, the person claiming reimbursement shall submit all additional information requested by the insurer within 30 days after receipt of the request for additional information. Failure to furnish such additional information within the time required shall not invalidate nor reduce the claim if it was not reasonably possible to give such information within such time, provided such proof is furnished as soon as possible. Within 15 days

after receipt of all the requested additional information, an insurer issuing a policy of accident and sickness insurance shall pay a clean claim in accordance with this section or send a written or electronic notice that states: (1) Such insurer refuses to reimburse all or part of the claim; and (2) specifies each reason for denial. Any insurer issuing a policy of accident and sickness insurance that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the rate of 1% per month. The provisions of subsection shall not apply when there is a good faith dispute about the legitimacy of the claim, or when there is a reasonable basis supported by specific information that such claim was submitted fraudulently. In the event that an insurer erroneously pays a claim providing benefits to which the insured person or provider is not entitled, the insurer shall not initiate a request for reimbursement or refund of that erroneous payment, or in any other way seek to recoup the erroneous payment, unless such action is initiated within 18 months after the end of the month in which the erroneous payment was made. In cases of fraud by the insured person or provider, such action may be initiated within the applicable statute of limitations.

K.S.A. 40-2442

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

No health insurer shall prohibit or restrict any participating provider from discussing with or disclosing to any insured or other individual any medically appropriate health care information that such provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by such insurer to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of the insured within the utilization review or grievance processes established by the health insurer.

K.S.A. 40-4604

Required Content in Contract

No state-specific requirements.

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.

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