

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

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

No state-specific requirements.

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

For health carriers or third-party contractors subject to insurance laws and regulations of the State of Missouri, within ten working days after receipt of a claim by a health carrier or a third-party contractor, a health carrier shall: send an acknowledgment of the date of receipt; or send notice of the status of the claim that includes a request for additional information; or pay the claim. Within fifteen days after receipt of additional information by a health carrier or a third-party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send a notice of receipt and status of the claim: that denies all or part of the claim and specifies each reason for denial; or that makes a final request for additional information. Within fifteen days after the day on which the health carrier or a third-party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny or suspend the claim. If the health carrier has not paid the claimant on or before the forty-fifth day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month. The interest shall be calculated based upon the unpaid balance of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest. A health carrier may combine interest payments and make payment once the aggregate amount reaches five dollars. If a health carrier fails to pay, deny or suspend the claim within forty processing days, and has received, on or after the fortieth day, notice from the health care provider that such claim has not been paid, denied or suspended, the health carrier shall, in addition to monthly interest due, pay to the claimant per day an amount of fifty percent of the claim but not to exceed twenty dollars for failure to pay all or part of a claim or interest due thereon or deny or suspend as required by this section. Such penalty shall not accrue for more than thirty days unless the claimant provides a second written or electronic notice on or after the thirty days to the health carrier that the claim remains unpaid.

and that penalties are claimed to be due pursuant to this section. Penalties shall cease if the health carrier pays, denies or suspends the claim. Said penalty shall also cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense. The department of insurance, financial institutions and professional registration shall monitor suspensions and determine whether the health carrier acted reasonably. If a health carrier or third-party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third-party contractor shall notify the department of insurance, financial institutions and professional registration of the fraudulent claim pursuant to applicable law. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied. Requests for additional information shall specify what additional information is necessary to process the claim for payment. Information requested shall be reasonable and pertain to the health carrier's determination of liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five working days or pay the claim.

V.A.M.S. 376.383

All health carriers subject to insurance laws and regulations of the State of Missouri shall: permit nonparticipating health care providers to file a claim for reimbursement for a health care service provided in this state as defined by applicable law for a period of up to one year from the date of service; permit participating health care providers to file a claim for reimbursement for a health care service provided in this state for a period of up to six months from the date of service, unless the contract between the health carrier and health care provider specifies a different standard; not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider; and issue within one working day a confirmation of receipt of an electronically filed claim.

Section 376.384

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 state-specific requirements.

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.

Last modified September 12, 2017.