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

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
A health carrier and participating provider shall provide at least 60 days' written notice to each other before terminating the contract between them without cause. The health carrier shall make a good faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a notice of termination from or to a participating provider, to all covered persons who are patients seen on a regular basis by the participating provider whose contract is terminating, irrespective of whether the termination is for cause or without cause. If a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional must be notified.
MCA 33-36-204

Dispute Resolution Process
Please see Network Appeals/Grievances.

A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between the health carrier and participating providers.
MCA 33-36-204

Network Participation Procedures
A health carrier shall adopt standards for selecting participating providers who are primary care professionals and for each health care professional specialty within the health carrier's network. The health carrier shall use the standards to select health care professionals, the health carrier's intermediaries, and any provider network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow the health carrier to: (a) avoid high-risk populations by excluding a provider because the provider is located in a geographic area that contains populations or providers presenting a risk of higher than average claims, losses, or use of health care services; or (b) exclude a provider because the provider treats or specializes in treating populations presenting a risk of higher than average claims, losses, or use of health care services. A health carrier may decline to select a provider who fails to meet the other legitimate selection criteria of the health carrier. This does not require a health carrier, its intermediary, or a provider network with which the health carrier or its intermediary contract to employ specific providers or types of providers who may meet their selection criteria or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network. A health carrier may use criteria established in accordance with the provisions of this section to select health care professionals allowed to participate in the health carrier's managed care plan. A health carrier shall make its selection standards for participating providers available for review by the department and by each health care professional who is subject to the selection standards.

MCA 33-36-203

A health carrier offering a managed care plan shall notify, in writing, prospective participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and applicable federal or state requirements. A health carrier may not offer an inducement under a managed care plan to a participating provider to provide less than medically necessary services to a covered person.
MCA 33-36-204

Quality of Care Procedures
A health carrier shall require a participating provider to make health records available to appropriate state and federal authorities, in accordance with the applicable state and federal laws related to the confidentiality of medical or health records, when the authorities are involved in assessing the quality of care or investigating a grievance or complaint of a covered person.
MCA 33-36-204

Claims Procedures
A health carrier shall notify the participating providers of their obligation, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage or of the participating providers' obligations, if any, to notify covered persons of the covered persons' personal financial obligations for noncovered benefits.
MCA 33-36-204

A health carrier shall establish a mechanism by which a participating provider may determine in a timely manner whether or not a person is covered by the health carrier.
MCA 33-36-204

A health carrier shall ensure that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser or as a participant in a publicly financed program of health care services. This requirement does not apply to circumstances in which the participating provider should not render services because of the participating provider's lack of training, experience, or skill or because of a restriction on the participating provider's license.
MCA 33-36-204

Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. Whenever a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers or shall make other arrangements acceptable to the department.
MCA 33-36-201

An insurer shall pay or deny a claim within 30 days after receipt of a proof of loss unless the insurer makes a reasonable request for additional information or documents in order to evaluate the claim. If an insurer makes a reasonable request for additional information or documents, the insurer shall pay or deny the claim within 60 days of receiving the proof of loss unless the insurer has notified the insured, the insured's assignee, or the claimant of the reasons for failure to pay the claim in full or unless the insurer has a reasonable belief that insurance fraud has been committed and the insurer has reported the possible insurance fraud to the commissioner. This section does not eliminate an insurer's right to conduct a thorough investigation of all the facts necessary to determine payment of a claim. If an insurer fails to comply with this section and the insurer

is liable for payment of the claim, the insurer shall pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after the insurer's receipt of the proof of loss or 60 days after receipt of the proof of loss if the insurer made a reasonable request for information or documents. Interest payments must be made to the person who receives the claims payment. Interest is payable under this subsection only if the amount of interest due on a claim exceeds $5.
MCA 33-18-232

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

<u>Provider-Patient Relationship</u>
A health carrier may not prohibit a participating provider from discussing a treatment option with a covered person or from advocating on behalf of a covered person within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.
MCA 33-36-204

All policies or certificates of disability insurance, including individual, group, and blanket policies or certificates, must provide that the insured has full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse as specifically listed in applicable law for treatment of any illness or injury within the scope and limitations of the person's practice. Whenever the policies or certificates insure against the expense of drugs, the insured has full freedom of choice in the selection of any licensed and registered pharmacist.

MCA 33-22-111

A health carrier may not penalize a participating provider because the participating provider, in good faith, reports to state or federal authorities an act or practice by the health carrier that may adversely affect patient health or welfare.
MCA 33-36-204

Required Content in Contract

- The provider agrees that the provider may not for any reason, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a covered person or a person other than the health carrier or intermediary acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person. This agreement does not prohibit a provider, except a health care professional who is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person if the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available for obtaining payment for services from the health carrier.
- If a health carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered persons will continue through the end of the period for which a premium has been paid to the health carrier on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from an acute care inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an acute care inpatient facility on the date of insolvency or other cessation of operations must be continued by a provider until the confinement in an inpatient facility is no longer medically necessary.
- These contract provisions shall be construed in favor of the covered person, survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and supersede an oral or written contrary agreement between a participating provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by this section.
- A participating provider may not collect or attempt to collect from a covered person money owed to the provider by the health carrier.

MCA 33-36-202

A contract between a health carrier and a participating provider may not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this chapter.
MCA 33-36-204

A contract between a health carrier and a participating provider shall set forth all of the responsibilities and obligations of the provider either in the contract or documents referenced in the contract. A health carrier shall make its best effort to furnish copies of any reference documents, if requested by a participating provider, prior to execution of the contract.
MCA 33-36-204

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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