

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

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.

Termination Procedures

A managed care organization may not terminate a contract with, demote, refuse to contract with or refuse to compensate a provider of health care solely because the provider, in good faith: (1) advocates in private or in public on behalf of a patient; (2) assists a patient in seeking reconsideration of a decision by the managed care organization to deny coverage for a health care service; or (3) reports a violation of law to an appropriate authority.

NRS 695G.410

Dispute Resolution Process

Please see Network Appeals/Grievances.

Network Participation Procedures

If a managed care organization contracts with a hospital or other licensed health care facility that provides acute care for the provision of emergency medical, outpatient or inpatient services and that hospital or facility is located in a city whose population is less than 45,000 or in a county whose population is less than 100,000, the managed care organization cannot prohibit the insured from receiving care or services at that facility if the managed care organization has contracted with that facility to provide those services. The managed care organization also cannot refuse to pay a health care provider with whom the managed care organization has contracted for the provision of services at that hospital or facility. The managed care organization cannot offer or pay any financial incentive to a provider to provide services at another hospital or facility if the service is covered by the plan.

1999 Nevada Laws Ch. 411

If a managed care organization contracts for the provision of emergency medical services, outpatient services or inpatient services with a hospital or other licensed health care facility that provides acute care and is located in a city whose population is less than 60,000 or a county whose population is less than 100,000, the managed care organization shall not: (a) Prohibit an insured from receiving services covered by the health care plan of the insured at that hospital or licensed health care facility if the services are provided by a provider of health care with whom the managed care organization has contracted for the provision of the services; (b) Refuse to provide coverage for services covered by the health care plan of an insured that are provided to the insured at that hospital or licensed health care facility if the services were provided by a provider of health care with whom the managed care organization has contracted for the provision of the services; (c) Refuse to pay a provider of health care with whom the managed care organization has contracted for the provision of services for providing services to an insured at that hospital or licensed health care facility if the services are covered by

the health care plan of the insured; (d) Discourage a provider of health care with whom the managed care organization has contracted for the provision of services from providing services to an insured at that hospital or licensed health care facility that are covered by the health care plan of the insured; or (e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care: (1) To provide services to an insured that are covered by the health care plan of the insured at another hospital or licensed health care facility; or (2) Not to provide services to an insured at that hospital or licensed health care facility that are covered by the health care plan of the insured.

N.R.S. 695G.175

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

An insurer must approve or deny a claim relating to a policy of health insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the insurer shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

If the insurer requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed by law.

An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

An insurer shall not pay only part of a claim that has been approved and is fully payable.

N.R.S. 689A.410

An insurer, organization for managed care or third party administrator shall respond to a written request for prior authorization for treatment, diagnostic testing or consultation within 5 working days after receiving the written request. If the insurer, organization for managed care or third-party administrator fails to respond to such a request within 5 working days, authorization shall be deemed to be given. The insurer, organization for managed care or third-party administrator may subsequently deny authorization. If the insurer, organization for managed care or third-party administrator subsequently denies a request for authorization submitted by a provider of health care for additional visits or treatments, it shall pay for the additional visits or treatments actually provided to the injured employee, up to the number of treatments for which payment is requested by the provider of health care before the denial of authorization is received by the provider.

N.R.S. 616C.157

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

A managed care organization may not restrict or interfere with any communication between a provider of health care and his patient regarding any information that the provider of health care determines is relevant to health care of the patient.

N.R.S. 695G.400

A managed care organization cannot deny a claim under a health care plan solely because the claim involves an injury sustained by an insured as a consequence of being intoxicated or under the influence of a controlled substance; cancel participation under a health care plan solely because an insured has made a claim involving an injury sustained by the insured as a consequence of being intoxicated or under the influence of a controlled substance; or refuse participation under a health care plan to an eligible applicant solely because the applicant has made a claim involving an injury sustained by the applicant as a consequence of being intoxicated or under the influence of a controlled substance; provided that, managed care organizations are not prohibited from enforcing a provision included in a health care plan to deny a claim which involves an injury to which a contributing cause was the insured's commission of or attempt to commit a felony; cancel participation under a health care plan solely because of such a claim; or refuse participation under a health care plan to an eligible applicant solely because of such a claim.

N.R.S. 695G.405

A managed care organization cannot terminate a contract with, demote, refuse to contract with or refuse to compensate a provider of health care solely because the provider advocates on behalf of a patient; assists a patient in seeking reconsideration of a decision by the managed care organization to deny coverage from a health care service; or reports a violation of law to an appropriate authority.

N.R.S. 695G.410

A woman covered by a policy of health insurance must be allowed to obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.

N.R.S. 689A.0413

Required Content in Contract

The network does not offer or pay a financial incentive to a Participating Provider to deny, reduce, withhold, limit or delay medically necessary services.

N.R.S. 616B.529

This contract does not restrict or interfere with the right of any person entitled to service and care in a hospital to select the contacting hospital or to make a free choice of his attending physician, who must be the holder of a valid and unrevoked physician's license and a member of, or acceptable to, the attending staff and board of directors of the hospital in which the services are to be provided.

N.R.S. 695B.180

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.